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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,611,603.86	ADJUSTMENTS	642,666.85
COVERED CHARGES	38,087,255.00	CONTRACTUAL ALLOW	31,309,256.61
NON-COVERD CHARGES	524,348.86	TOTAL MEDICAID LIAB	6,777,998.39
		LESS: COB	33,537.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	14,238.00
		REIMBURSEMENT	6,758,699.37

TOTAL NUMBER OF ADMISSIONS 1,056

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,800	0	6,313,600.00	0.00
ROUTINE NURSERY	1,228	0	2,897,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,028	0	9,210,800.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	431	0	2,219,300.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	431	0	2,219,300.00	0.00
TOTAL ACCOMODATIONS	4,459	0	11,430,100.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,390,282.10	0.00
MED/SURG SUPPLY	1,072,501.77	0.00
LABORATORY-GENERAL	4,814,129.52	0.00
RADIOLOGY-DIAGNOSTIC	481,779.08	0.00
CT SCAN	1,518,650.10	4,024.00
PHYSICAL THERAPY	198,039.05	0.00
EKG/ECG	275,384.75	0.00
IV THERAPY	13,370.00	0.00
OPERATING ROOM	2,793,959.80	0.00
LABOR/DELIVERY ROOM	498,788.36	0.00
RESPIRATORY SERVICES	4,010,156.81	0.00
ANESTHESIA	322,091.37	0.00
GI SERVICES	112,617.23	0.00
EMERGENCY ROOM	2,686,298.38	0.00
RECOVERY ROOM	446,450.00	0.00
LABORATORY PATHOLOGIC	129,603.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	41,796.16	0.00
SPEECH PATHOLOGY	122,783.70	0.00
RENAL DIALYSIS	245,217.81	34,778.67
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,661.18	1,061.56
PSYCHIATRIC SERVICES	6,705.50	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	527,151.01	0.00
BLOOD	7,028.00	0.00
BLOOD STORAGE & PRO.	234,069.04	380,514.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	160,334.80	22,933.00
AUDIOLOGY	3,003.40	34,770.15
CARDIOLOGY	1,037,567.48	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	39,919.89	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	49,312.77	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	162,519.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	10,446.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	234,902.38	0.00
PROFESSIONAL FEES	0.00	543.38
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	35,277.00
INJECTABLE DRUGS	2,723,814.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	290,215.01	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,051.82	0.00

TOTAL ANCILLARY	26,657,155.00	524,348.86
TOTAL ACCOMODATIONS	11,430,100.00	0.00
TOTAL CHARGES	38,087,255.00	524,348.86

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023164000250	06/04/23 - 06/07/23	06/19/23	4,051.82	0.00	0.00	0.00	0.00
TOTAL				4,051.82	0.00	0.00	0.00	0.00

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	575,733.07	ADJUSTMENTS	0.00
COVERED CHARGES	558,534.67	CONTRACTUAL ALLOW	463,670.19
NON-COVERD CHARGES	17,198.40	TOTAL MEDICAID LIAB	94,864.48
		LESS: COB	94,864.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	44	0	96,400.00	0.00
ROUTINE NURSERY	2	0	2,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	0	99,200.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	42,300.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	42,300.00	0.00
TOTAL ACCOMODATIONS	55	0	141,500.00	0.00

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
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RIVERDALE,GA 30274-2615

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,893.36	0.00
MED/SURG SUPPLY	10,940.48	0.00
LABORATORY-GENERAL	74,346.69	0.00
RADIOLOGY-DIAGNOSTIC	8,180.62	0.00
CT SCAN	31,248.33	0.00
PHYSICAL THERAPY	9,217.94	0.00
EKG/ECG	6,705.02	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18,627.71	0.00
LABOR/DELIVERY ROOM	5,088.65	0.00
RESPIRATORY SERVICES	46,760.72	0.00
ANESTHESIA	1,123.08	0.00
GI SERVICES	19,921.10	0.00
EMERGENCY ROOM	38,665.34	0.00
RECOVERY ROOM	4,800.00	0.00
LABORATORY PATHOLOGIC	1,185.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,423.49	0.00
SPEECH PATHOLOGY	12,196.92	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,459.42	0.00
BLOOD	1,004.00	0.00
BLOOD STORAGE & PRO.	7,452.49	17,198.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,395.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,704.67	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,067.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,955.72	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64,671.92	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	417,034.67	17,198.40
TOTAL ACCOMODATIONS	141,500.00	0.00
TOTAL CHARGES	558,534.67	17,198.40

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,658,815.60	ADJUSTMENTS	417,115.32
COVERED CHARGES	13,485,191.41	CONTRACTUAL ALLOW	11,529,512.14
NON-COVERD CHARGES	1,173,624.19	TOTAL MEDICAID LIAB	1,955,679.27
		LESS: COB	6,314.46
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,949,364.81
		ALL OTHER	1,827,334.76
		FEE SCHEDULE-LAB	111,053.72
		INJECTABLE DRUGS	10,976.33

TOTAL NUMBER OF CLAIMS 2,983

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,032.25	1,123.47
MED/SURG SUPPLY	165,580.70	1,152.11
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	507,261.45	5,979.70
CT SCAN	1,490,807.44	159,027.56
PHYSICAL THERAPY	144,961.59	5,956.36
EKG/ECG	195,882.37	11,973.25
IV THERAPY	1,164,227.10	44,244.62
OPERATING ROOM	386,887.78	221,422.56
LABOR/DELIVERY ROOM	16,717.47	4,559.31
RESPIRATORY SERVICES	40,450.22	12,419.74
ANESTHESIA	109,447.98	5,123.05
GI SERVICES	165,003.68	24,208.70
EMERGENCY ROOM	5,211,675.02	8,472.25
RECOVERY ROOM	192,200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	43,325.93	20,700.28
SPEECH PATHOLOGY	0.00	4,150.95
RENAL DIALYSIS	0.00	23,349.46
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,333.83	949.80
PSYCHIATRIC SERVICES	13,411.00	10,931.15
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	264,393.66	41,411.34
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41,911.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,644.20	10,766.29
AUDIOLOGY	0.00	0.00
CARDIOLOGY	111,809.48	14,486.43
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	144,384.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	334,978.99	187,547.53

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,701.63	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	8,357.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,295,020.64	212,363.50
MRI SERVICES	63,688.30	23,017.09
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	6,730.60
INJECTABLE DRUGS	66,334.30	102,424.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	184,388.29	775.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	730.36	0.00

TOTAL ANCILLARY	13,485,191.41	1,173,624.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,485,191.41	1,173,624.19

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2223082010246	02/02/23 - 02/02/23	03/27/23	730.36	0.00	0.00	0.00	113.41
TOTAL				730.36	0.00	0.00	0.00	113.41

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	582,195.22	ADJUSTMENTS	0.00
COVERED CHARGES	211,097.99	CONTRACTUAL ALLOW	180,672.86
NON-COVERD CHARGES	371,097.23	TOTAL MEDICAID LIAB	30,425.13
		LESS: COB	30,425.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
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SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332.75	0.00
MED/SURG SUPPLY	7,402.98	121,312.34
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,518.40	14,618.15
CT SCAN	0.00	47,579.86
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,310.37	478.93
IV THERAPY	21,373.93	3,958.92
OPERATING ROOM	0.00	121,742.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	420.96	0.00
ANESTHESIA	2,157.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	93,199.84	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,584.74	2,533.02
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,386.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,283.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	43,515.39	4,170.57
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	611.93	1,991.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	52,711.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	211,097.99	371,097.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,097.99	371,097.23

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	947,433.51	ADJUSTMENTS	671.30
COVERED CHARGES	890,394.24	CONTRACTUAL ALLOW	860,320.00
NON-COVERD CHARGES	57,039.27	TOTAL MEDICAID LIAB	30,074.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	30,074.24

TOTAL NUMBER OF CLAIMS 448

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	720.90	0.00
MED/SURG SUPPLY	3,930.26	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,278.11	3,106.25
CT SCAN	74,378.35	25,124.74
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,494.32	478.93
IV THERAPY	34,759.84	5,294.96
OPERATING ROOM	599.76	0.00
LABOR/DELIVERY ROOM	1,519.77	0.00
RESPIRATORY SERVICES	0.00	1,555.58
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	541,785.13	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,341.10
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,467.93	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,858.39	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,283.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	158,652.12	16,882.32
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	666.36	3,255.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	890,394.24	57,039.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	890,394.24	57,039.27

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,130.82	ADJUSTMENTS	0.00
COVERED CHARGES	41,775.08	CONTRACTUAL ALLOW	40,499.61
NON-COVERD CHARGES	1,355.74	TOTAL MEDICAID LIAB	1,275.47
		LESS: COB	1,275.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 19

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,733.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,231.61	537.90
EKG/ECG	957.86	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	854.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,988.31	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	189.14	11.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	806.26	806.26	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,775.08	1,355.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,775.08	1,355.74

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,993,617.18	ADJUSTMENTS	42,226.39
COVERED CHARGES	1,663,527.91	CONTRACTUAL ALLOW	1,500,014.96
NON-COVERD CHARGES	330,089.27	TOTAL MEDICAID LIAB	163,512.95
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	163,512.95

TOTAL NUMBER OF CLAIMS 31

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,065.02	0.00
MED/SURG SUPPLY	213,592.59	13,812.64
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,791.15	3,706.55
CT SCAN	2,594.31	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	42,573.29	4,304.12
OPERATING ROOM	855,165.20	127,961.85
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,025.52	0.00
ANESTHESIA	108,357.48	5,355.63
GI SERVICES	7,073.75	3,657.00
EMERGENCY ROOM	10,795.86	0.00
RECOVERY ROOM	108,807.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,248.05	4,275.09
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	6,032.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	81,182.82	39,898.04

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,731.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,089.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	39,657.59	2,487.84
MRI SERVICES	0.00	6,082.89
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,149.28	14,604.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	166,717.10	95,822.10
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,663,527.91	330,089.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,663,527.91	330,089.27

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

PRIME HEALTHCARE FOUNDATION-SOUTHERN REGIONAL LLC
11 UPPER RIVERDALE RD SW
RIVERDALE,GA 30274-2615

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	174,358.18	ADJUSTMENTS	0.00
COVERED CHARGES	173,849.18	CONTRACTUAL ALLOW	124,858.92
NON-COVERD CHARGES	509.00	TOTAL MEDICAID LIAB	48,990.26
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	48,990.26

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	87	0	76,125.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	87	0	76,125.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	87	0	76,125.00	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,920.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,431.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,801.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,422.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,035.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	392.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,633.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,714.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	848.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,017.00	509.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,562.00	0.00			

TOTAL ANCILLARY	97,724.18	509.00
TOTAL ACCOMODATIONS	76,125.00	0.00
TOTAL CHARGES	173,849.18	509.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	956,115.32	ADJUSTMENTS	14,234.70
COVERED CHARGES	834,101.07	CONTRACTUAL ALLOW	661,412.34
NON-COVERD CHARGES	122,014.25	TOTAL MEDICAID LIAB	172,688.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	172,688.73
		ALL OTHER	147,523.31
		FEE SCHEDULE-LAB	24,163.97
		INJECTABLE DRUGS	1,001.45

TOTAL NUMBER OF CLAIMS 694

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,773.75	0.00
MED/SURG SUPPLY	2,292.82	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,976.00	596.00
CT SCAN	193,429.00	90,974.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	13,720.00	196.00
IV THERAPY	36,967.00	7,471.00
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	255,930.00	451.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	260.00	130.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	27,714.00	1,886.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,196.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	194,182.00	6,650.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,440.50	13,660.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	834,101.07	122,014.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	834,101.07	122,014.25

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,677.90	ADJUSTMENTS	0.00
COVERED CHARGES	8,336.90	CONTRACTUAL ALLOW	8,201.70
NON-COVERD CHARGES	341.00	TOTAL MEDICAID LIAB	135.20
		LESS: COB	135.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280.75	0.00
MED/SURG SUPPLY	34.90	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	361.00	0.00
CT SCAN	4,735.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	164.00	317.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	763.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,251.00	24.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	747.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,336.90	341.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,336.90	341.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,982.37	ADJUSTMENTS	156.64
COVERED CHARGES	70,343.85	CONTRACTUAL ALLOW	63,295.05
NON-COVERD CHARGES	8,638.52	TOTAL MEDICAID LIAB	7,048.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,048.80

TOTAL NUMBER OF CLAIMS 90

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	679.75	0.00
MED/SURG SUPPLY	217.10	71.77
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,661.00	0.00
CT SCAN	2,995.00	7,730.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,372.00	0.00
IV THERAPY	2,525.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	43,850.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,710.00	580.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,334.00	256.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	70,343.85	8,638.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,343.85	8,638.52

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	638.00	ADJUSTMENTS	0.00
COVERED CHARGES	638.00	CONTRACTUAL ALLOW	559.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	153.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	485.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	638.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	638.00	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
1221 E MCPHERSON AVE
NASHVILLE,GA 31639-2326

PROVIDER NUMBER
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	456,265.07	ADJUSTMENTS	0.00
COVERED CHARGES	454,413.07	CONTRACTUAL ALLOW	415,643.57
NON-COVERD CHARGES	1,852.00	TOTAL MEDICAID LIAB	38,769.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	38,769.50

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	175	0	139,300.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	175	0	139,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	175	0	139,300.00	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,724.25	0.00
MED/SURG SUPPLY	51,275.82	0.00
LABORATORY-GENERAL	82,469.00	0.00
RADIOLOGY-DIAGNOSTIC	5,697.00	0.00
CT SCAN	14,077.00	0.00
PHYSICAL THERAPY	2,014.00	0.00
EKG/ECG	1,568.00	0.00
IV THERAPY	5,506.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,746.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,193.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	341.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	290.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,978.00	1,852.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,361.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,804.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,069.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	315,113.07	1,852.00
TOTAL ACCOMODATIONS	139,300.00	0.00
TOTAL CHARGES	454,413.07	1,852.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,534,022.45	ADJUSTMENTS	114,422.60
COVERED CHARGES	2,231,180.07	CONTRACTUAL ALLOW	1,740,108.91
NON-COVERD CHARGES	302,842.38	TOTAL MEDICAID LIAB	491,071.16
		LESS: COB	1,736.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	489,334.76
		ALL OTHER	372,445.21
		FEE SCHEDULE-LAB	47,930.98
		INJECTABLE DRUGS	68,958.57

TOTAL NUMBER OF CLAIMS 1,128

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,856.25	0.00
MED/SURG SUPPLY	78,999.93	93.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,392.00	579.00
CT SCAN	136,348.00	96,128.00
PHYSICAL THERAPY	0.00	2,412.00
EKG/ECG	10,780.00	196.00
IV THERAPY	32,789.00	2,703.00
OPERATING ROOM	180,406.00	31,293.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	970.00	970.00
ANESTHESIA	157,077.00	631.00
GI SERVICES	155,297.00	64,444.00
EMERGENCY ROOM	86,717.00	511.00
RECOVERY ROOM	205,917.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	214.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	130.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	40,569.00	3,604.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,275.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	239,960.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	70,389.00	8,839.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	16,752.00	4,102.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	334,645.00	16,343.00
MRI SERVICES	68,563.00	22,295.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	287,462.75	47,441.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	34,885.14	43.78
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,231,180.07	302,842.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,231,180.07	302,842.38

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,563.11	ADJUSTMENTS	0.00
COVERED CHARGES	18,683.11	CONTRACTUAL ALLOW	14,687.10
NON-COVERD CHARGES	11,880.00	TOTAL MEDICAID LIAB	3,996.01
		LESS: COB	3,996.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	416.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	303.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	940.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,695.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,133.00	398.00
EKG/ECG	196.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,873.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,332.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,843.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,054.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,638.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	183.75	7,222.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	918.00	1,417.00			

TOTAL ANCILLARY	18,683.11	11,880.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,683.11	11,880.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,814.49	ADJUSTMENTS	67.13
COVERED CHARGES	19,724.24	CONTRACTUAL ALLOW	18,314.51
NON-COVERD CHARGES	6,090.25	TOTAL MEDICAID LIAB	1,409.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,409.73

TOTAL NUMBER OF CLAIMS 21

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	531.75	0.00
MED/SURG SUPPLY	102.49	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,435.00	0.00
CT SCAN	1,431.00	4,735.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	588.00	0.00
IV THERAPY	1,393.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,189.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,054.00	47.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,178.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,724.24	6,090.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,724.24	6,090.25

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	858,935.05	ADJUSTMENTS	16,174.41
COVERED CHARGES	782,580.08	CONTRACTUAL ALLOW	658,576.27
NON-COVERD CHARGES	76,354.97	TOTAL MEDICAID LIAB	124,003.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	124,003.81

TOTAL NUMBER OF CLAIMS 23

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,246.75	0.00
MED/SURG SUPPLY	27,747.12	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,145.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	306.00
EKG/ECG	0.00	0.00
IV THERAPY	2,145.00	0.00
OPERATING ROOM	319,119.03	52,970.97
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	85,419.00	1,262.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	95,594.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	864.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	16,870.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	502.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78,251.25	4,946.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	163,546.93	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	782,580.08	76,354.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	782,580.08	76,354.97

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

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY
4280 N VALDOSTA ROAD
VALDOSTA,GA 31602-6814

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	500,764.63	ADJUSTMENTS	0.00
COVERED CHARGES	500,764.63	CONTRACTUAL ALLOW	309,641.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	191,122.89
		LESS: COB	2,585.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	188,537.66

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	80	0	87,400.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	80	0	87,400.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	80	0	87,400.00	0.00

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,742.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64,148.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,494.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,089.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,680.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,720.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,698.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,629.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,946.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,353.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,221.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,636.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,283.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	270.86	0.00	INJECTABLE DRUGS	350.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	928.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,260.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	900.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,092.05	0.00			
ONCOLOGY	1,241.95	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,597.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,084.00	0.00			

TOTAL ANCILLARY	413,364.63	0.00
TOTAL ACCOMODATIONS	87,400.00	0.00
TOTAL CHARGES	500,764.63	0.00

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,712,884.43	ADJUSTMENTS	69,900.14
COVERED CHARGES	1,620,301.67	CONTRACTUAL ALLOW	1,305,096.67
NON-COVERD CHARGES	92,582.76	TOTAL MEDICAID LIAB	315,205.00
		LESS: COB	589.77
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	314,615.23
		ALL OTHER	288,385.97
		FEE SCHEDULE-LAB	24,236.00
		INJECTABLE DRUGS	1,993.26

TOTAL NUMBER OF CLAIMS 593

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,022.18	0.00
MED/SURG SUPPLY	132,231.45	10,117.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,034.00	0.00
CT SCAN	310,194.00	29,484.00
PHYSICAL THERAPY	797.00	1,455.00
EKG/ECG	39,819.00	354.00
IV THERAPY	134,048.00	0.00
OPERATING ROOM	77,931.00	8,501.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,209.00	2,105.00
ANESTHESIA	9,244.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	405,192.00	754.00
RECOVERY ROOM	13,210.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	845.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,229.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	18,627.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,611.90	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,535.00	180.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,937.00	189.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	19,896.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	209,000.19	6,046.01
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	48,533.95	32,552.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,620,301.67	92,582.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,620,301.67	92,582.76

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,806.34	ADJUSTMENTS	0.00
COVERED CHARGES	2,806.34	CONTRACTUAL ALLOW	2,305.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	500.94
		LESS: COB	500.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	160.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	325.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	633.85	0.00
EKG/ECG	354.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	437.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	754.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,806.34	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,806.34	0.00

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,294.73	ADJUSTMENTS	0.00
COVERED CHARGES	47,021.51	CONTRACTUAL ALLOW	45,063.51
NON-COVERD CHARGES	1,273.22	TOTAL MEDICAID LIAB	1,958.00
		LESS: COB	52.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,905.74

TOTAL NUMBER OF CLAIMS 25

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,129.75	0.00
MED/SURG SUPPLY	1,582.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,585.00	0.00
CT SCAN	14,244.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	970.00	0.00
IV THERAPY	2,604.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,863.00	920.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	801.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,650.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	592.76	353.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	47,021.51	1,273.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,021.51	1,273.22

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	239,761.39	ADJUSTMENTS	32,414.52
COVERED CHARGES	217,278.71	CONTRACTUAL ALLOW	184,864.19
NON-COVERD CHARGES	22,482.68	TOTAL MEDICAID LIAB	32,414.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	32,414.52

TOTAL NUMBER OF CLAIMS 6

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,509.12	0.00
MED/SURG SUPPLY	122,384.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,118.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	8,203.00
EKG/ECG	0.00	0.00
IV THERAPY	17,308.00	0.00
OPERATING ROOM	32,582.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	704.00	0.00
ANESTHESIA	6,471.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,937.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	8,611.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,221.65	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,043.54	5,668.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	217,278.71	22,482.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,278.71	22,482.68

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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER
2460 WASHINTGON ROAD N.E.
THOMSON,GA 30824-2199

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,601,408.41	ADJUSTMENTS	1,599,468.05
COVERED CHARGES	34,681,831.46	CONTRACTUAL ALLOW	31,428,027.98
NON-COVERD CHARGES	919,576.95	TOTAL MEDICAID LIAB	3,253,803.48
		LESS: COB	3,076.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,250,726.68

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,957	0	10,510,097.78	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,957	0	10,510,097.78	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,957	0	10,510,097.78	0.00

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,078,806.88	0.00
MED/SURG SUPPLY	2,123,638.08	0.00
LABORATORY-GENERAL	975,588.74	0.00
RADIOLOGY-DIAGNOSTIC	201,484.52	0.00
CT SCAN	0.00	131,304.56
PHYSICAL THERAPY	436,423.02	0.00
EKG/ECG	1,264,028.34	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	110,097.49	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,637,373.20	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	434,309.43	0.00
SPEECH PATHOLOGY	244,995.21	0.00
RENAL DIALYSIS	543,715.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,019.78	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	51,107.75	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,571.96	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	46,055.00	0.00
OTHER THERAPEUTIC SVC	0.00	428,410.33
SPECIAL CHARGES	2,519.28	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	359,862.06
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,171,733.68	919,576.95
TOTAL ACCOMODATIONS	10,510,097.78	0.00
TOTAL CHARGES	34,681,831.46	919,576.95

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/22	THROUGH	08/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - MIDTOWN ATLANTA, LLC
705 JUNIPER ST NE
ATLANTA,GA 30308-1307

PROVIDER NUMBER
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,086,859.95	ADJUSTMENTS	2,360,871.23
COVERED CHARGES	148,971,419.73	CONTRACTUAL ALLOW	134,025,444.73
NON-COVERD CHARGES	115,440.22	TOTAL MEDICAID LIAB	14,945,975.00
		LESS: COB	166,361.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	25,011.00
		REIMBURSEMENT	14,804,624.79

TOTAL NUMBER OF ADMISSIONS 1,787

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,402	0	14,611,908.00	0.00
ROUTINE NURSERY	982	0	4,371,378.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,384	0	18,983,286.50	0.00
SPECIAL CARE SERVICES				
CCU	2,104	0	14,931,644.00	0.00
ICU	969	0	7,390,936.00	0.00
NICU	1,144	0	12,970,480.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	82	0	879,860.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,299	0	36,172,920.00	0.00
TOTAL ACCOMODATIONS	10,683	0	55,156,206.50	0.00

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,151,202.84	0.00
MED/SURG SUPPLY	3,182,231.67	5,403.62
LABORATORY-GENERAL	15,965,821.78	0.00
RADIOLOGY-DIAGNOSTIC	1,607,611.00	0.00
CT SCAN	6,239,326.00	3,638.00
PHYSICAL THERAPY	592,788.50	0.00
EKG/ECG	990,620.00	0.00
IV THERAPY	1,211,312.00	0.00
OPERATING ROOM	9,874,822.23	0.00
LABOR/DELIVERY ROOM	3,521,439.00	0.00
RESPIRATORY SERVICES	9,695,172.04	0.00
ANESTHESIA	3,205,871.14	0.00
GI SERVICES	1,021,949.00	0.00
EMERGENCY ROOM	3,631,450.00	0.00
RECOVERY ROOM	943,681.00	0.00
LABORATORY PATHOLOGIC	463,581.00	0.00
RADIOLOGY THERAPEUTIC	67,326.00	0.00
OCCUPATIONAL THERAPY	471,062.00	0.00
SPEECH PATHOLOGY	199,945.00	0.00
RENAL DIALYSIS	0.00	83,997.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	72,611.00	2,596.00
PSYCHIATRIC SERVICES	26,308.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	459,259.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,360,549.00	7,090.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	320,366.10	3,882.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,201,726.57	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	201,870.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,351,428.83	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,534,801.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	63,456.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,276,115.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	8,833.60
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,909,510.53	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	93,815,213.23	115,440.22
TOTAL ACCOMODATIONS	55,156,206.50	0.00
TOTAL CHARGES	148,971,419.73	115,440.22

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,785,080.24	ADJUSTMENTS	0.00
COVERED CHARGES	2,784,758.24	CONTRACTUAL ALLOW	2,584,786.44
NON-COVERD CHARGES	322.00	TOTAL MEDICAID LIAB	199,971.80
		LESS: COB	200,664.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	693.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	71	0	183,631.00	0.00
ROUTINE NURSERY	31	0	155,410.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	102	0	339,041.00	0.00
SPECIAL CARE SERVICES				
CCU	28	0	198,016.00	0.00
ICU	18	0	127,296.00	0.00
NICU	46	0	520,812.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	92	0	846,124.00	0.00
TOTAL ACCOMODATIONS	194	0	1,185,165.00	0.00

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,549.10	0.00
MED/SURG SUPPLY	70,993.15	0.00
LABORATORY-GENERAL	225,814.00	0.00
RADIOLOGY-DIAGNOSTIC	37,931.00	0.00
CT SCAN	66,317.00	0.00
PHYSICAL THERAPY	3,722.00	0.00
EKG/ECG	16,464.00	0.00
IV THERAPY	9,047.00	0.00
OPERATING ROOM	234,392.00	0.00
LABOR/DELIVERY ROOM	116,453.00	0.00
RESPIRATORY SERVICES	201,368.00	0.00
ANESTHESIA	91,865.00	0.00
GI SERVICES	15,792.00	0.00
EMERGENCY ROOM	30,370.00	0.00
RECOVERY ROOM	32,416.00	0.00
LABORATORY PATHOLOGIC	10,831.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,200.00	0.00
SPEECH PATHOLOGY	3,250.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,415.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,756.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,599.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,668.00	322.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,984.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,208.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	22,271.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,524.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,995.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,681.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,717.59	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,599,593.24	322.00
TOTAL ACCOMODATIONS	1,185,165.00	0.00
TOTAL CHARGES	2,784,758.24	322.00

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,513,728.51	ADJUSTMENTS	495,202.55
COVERED CHARGES	41,308,582.46	CONTRACTUAL ALLOW	36,535,768.31
NON-COVERD CHARGES	5,205,146.05	TOTAL MEDICAID LIAB	4,772,814.15
		LESS: COB	33,270.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,739,544.02
		ALL OTHER	3,650,633.75
		FEE SCHEDULE-LAB	491,586.27
		INJECTABLE DRUGS	597,324.00

TOTAL NUMBER OF CLAIMS 9,135

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	633,975.11	528.40
MED/SURG SUPPLY	507,787.15	7,566.22
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,349,426.00	4,834.00
CT SCAN	5,875,477.00	294,321.00
PHYSICAL THERAPY	413,384.00	29,876.00
EKG/ECG	724,415.00	14,112.00
IV THERAPY	3,234,631.00	67,121.00
OPERATING ROOM	1,343,028.24	357,427.76
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	235,567.00	157.00
ANESTHESIA	679,223.00	204.00
GI SERVICES	230,175.33	90,746.67
EMERGENCY ROOM	7,233,066.00	19,029.00
RECOVERY ROOM	274,746.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	609,484.00	68,122.00
OCCUPATIONAL THERAPY	9,480.00	9,392.00
SPEECH PATHOLOGY	5,840.00	5,049.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,035.00	5,801.00
PSYCHIATRIC SERVICES	0.00	725.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	653,831.50	37,577.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	115,951.00	24,520.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	196,363.24	80,914.30
AUDIOLOGY	0.00	0.00
CARDIOLOGY	413,264.00	66,911.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	245,918.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,131,317.58	469,235.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	551,847.00	32,107.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	649.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,371,815.03	200,434.91
MRI SERVICES	666,979.00	56,015.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,486,174.75	3,261,770.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	108,155.53	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	2,226.00	0.00

TOTAL ANCILLARY	41,308,582.46	5,205,146.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,308,582.46	5,205,146.05

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022216099591	07/08/22 - 07/08/22	08/08/22	159.00	0.00	0.00	0.00	20.52
780	2022216100010	07/06/22 - 07/06/22	08/08/22	159.00	0.00	0.00	0.00	20.52
780	2022227042613	07/28/22 - 07/28/22	08/22/22	159.00	0.00	0.00	0.00	20.52
780	2022242000013	08/23/22 - 08/23/22	09/05/22	159.00	0.00	0.00	0.00	20.52
780	2022242000063	08/24/22 - 08/24/22	09/05/22	159.00	0.00	0.00	0.00	20.52
780	2022248019883	08/15/22 - 08/15/22	09/12/22	159.00	0.00	0.00	0.00	20.52
780	2022308125465	10/17/22 - 10/17/22	11/14/22	159.00	0.00	0.00	0.00	20.52
780	2022348074430	11/21/22 - 11/21/22	12/19/22	159.00	0.00	0.00	0.00	20.52
780	2022349097757	07/11/22 - 07/11/22	12/19/22	159.00	0.00	0.00	0.00	20.52
780	5923066001310	11/21/22 - 11/21/22	03/13/23	159.00	0.00	0.00	0.00	20.52
780	2023068126216	02/06/23 - 02/06/23	03/13/23	159.00	0.00	0.00	0.00	20.52
780	2023068126449	02/01/23 - 02/01/23	03/13/23	159.00	0.00	0.00	0.00	20.52
780	2023070018644	02/06/23 - 02/06/23	03/20/23	159.00	0.00	0.00	0.00	20.52
780	2023123119326	04/03/23 - 04/03/23	05/08/23	159.00	0.00	0.00	0.00	20.52
TOTAL				2,226.00	0.00	0.00	0.00	287.28

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	469,490.56	ADJUSTMENTS	0.00
COVERED CHARGES	352,952.07	CONTRACTUAL ALLOW	314,546.30
NON-COVERD CHARGES	116,538.49	TOTAL MEDICAID LIAB	38,405.77
		LESS: COB	38,405.77
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 71

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,787.58	0.00
MED/SURG SUPPLY	4,361.68	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,175.00	0.00
CT SCAN	27,123.00	25,267.00
PHYSICAL THERAPY	1,469.00	603.00
EKG/ECG	7,840.00	784.00
IV THERAPY	58,787.00	786.00
OPERATING ROOM	11,145.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	754.00	0.00
ANESTHESIA	4,172.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,673.00	0.00
RECOVERY ROOM	2,352.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,310.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	644.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,583.00	5,674.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,337.00	6,130.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,262.00	2,273.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,110.98	2,596.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,057.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,947.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	82,582.33	2,061.68
MRI SERVICES	4,642.00	4,830.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,784.50	63,586.81
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	352,952.07	116,538.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	352,952.07	116,538.49

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	622,131.60	ADJUSTMENTS	134.26
COVERED CHARGES	597,799.80	CONTRACTUAL ALLOW	582,964.07
NON-COVERD CHARGES	24,331.80	TOTAL MEDICAID LIAB	14,835.73
		LESS: COB	57.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	14,777.93

TOTAL NUMBER OF CLAIMS 221

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,841.10	130.00	OTHER LAB	7,230.00	0.00
MED/SURG SUPPLY	707.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,757.00	670.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,000.00	7,658.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,206.00	725.00
EKG/ECG	10,976.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,318.00	404.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	365,653.00	1,474.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,990.70	790.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	161.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	5,800.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,160.00	12,480.00			

TOTAL ANCILLARY	597,799.80	24,331.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	597,799.80	24,331.80

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,011.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,205.90	CONTRACTUAL ALLOW	26,071.64
NON-COVERD CHARGES	805.60	TOTAL MEDICAID LIAB	134.26
		LESS: COB	134.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	563.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,545.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,516.00	0.00
EKG/ECG	784.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,241.00	786.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,488.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	68.70	19.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,205.90	805.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,205.90	805.60

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,707,173.99	ADJUSTMENTS	549,929.94
COVERED CHARGES	33,189,835.99	CONTRACTUAL ALLOW	31,190,974.14
NON-COVERD CHARGES	1,517,338.00	TOTAL MEDICAID LIAB	1,998,861.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,998,861.85

TOTAL NUMBER OF CLAIMS 371

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,456.50	1,189.70
MED/SURG SUPPLY	281,390.36	2,278.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,469.00	0.00
CT SCAN	75,944.00	4,142.00
PHYSICAL THERAPY	0.00	2,091.00
EKG/ECG	7,056.00	0.00
IV THERAPY	1,410,544.00	1,976.00
OPERATING ROOM	1,079,848.99	191,315.01
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,278.00	0.00
ANESTHESIA	363,497.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,541.00	0.00
RECOVERY ROOM	110,415.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,131,390.00	44,213.00
OCCUPATIONAL THERAPY	0.00	1,580.00
SPEECH PATHOLOGY	0.00	626.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	644.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,718.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,102.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	526.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,435.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	111,028.65	153,946.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,050.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	731,913.00	22,059.00
MRI SERVICES	12,213.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,704,462.18	1,090,751.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	895,084.31	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,189,835.99	1,517,338.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,189,835.99	1,517,338.00

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,872,093.19	ADJUSTMENTS	29,457.97
COVERED CHARGES	1,782,130.52	CONTRACTUAL ALLOW	1,123,416.40
NON-COVERD CHARGES	89,962.67	TOTAL MEDICAID LIAB	658,714.12
		LESS: COB	2,017.25
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	9,000.00
		REIMBURSEMENT	665,696.87

TOTAL NUMBER OF ADMISSIONS 103

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	324	0	227,448.00	0.00
ROUTINE NURSERY	45	0	18,470.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	369	0	245,918.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	65	0	119,795.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	65	0	119,795.00	0.00
TOTAL ACCOMODATIONS	434	0	365,713.00	0.00

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,039.45	6,506.27
MED/SURG SUPPLY	17,023.49	168.00
LABORATORY-GENERAL	285,848.00	2,574.00
RADIOLOGY-DIAGNOSTIC	24,712.00	0.00
CT SCAN	101,908.00	75,497.00
PHYSICAL THERAPY	42,201.00	0.00
EKG/ECG	23,958.00	0.00
IV THERAPY	46,104.00	0.00
OPERATING ROOM	46,645.00	0.00
LABOR/DELIVERY ROOM	54,259.00	0.00
RESPIRATORY SERVICES	244,162.00	0.00
ANESTHESIA	25,446.00	0.00
GI SERVICES	2,689.00	0.00
EMERGENCY ROOM	107,909.00	1,761.00
RECOVERY ROOM	2,972.00	0.00
LABORATORY PATHOLOGIC	1,042.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	32,479.00	0.00
SPEECH PATHOLOGY	3,562.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,033.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,494.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,759.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,302.00	3,456.40
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,304.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,858.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,863.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,429.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,296.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	77,370.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	17,750.28	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,416,417.52	89,962.67
TOTAL ACCOMODATIONS	365,713.00	0.00
TOTAL CHARGES	1,782,130.52	89,962.67

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,107,743.75	ADJUSTMENTS	109,654.95
COVERED CHARGES	2,852,348.15	CONTRACTUAL ALLOW	2,170,245.59
NON-COVERD CHARGES	255,395.60	TOTAL MEDICAID LIAB	682,102.56
		LESS: COB	2,208.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	679,893.82
		ALL OTHER	596,809.18
		FEE SCHEDULE-LAB	71,221.24
		INJECTABLE DRUGS	11,863.40

TOTAL NUMBER OF CLAIMS 1,532

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,067.38	7,895.80
MED/SURG SUPPLY	16,970.50	1,846.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,912.00	6,273.00
CT SCAN	646,175.00	90,172.00
PHYSICAL THERAPY	65,673.00	14,868.00
EKG/ECG	54,071.00	1,100.00
IV THERAPY	146,428.00	7,042.00
OPERATING ROOM	74,947.00	3,510.00
LABOR/DELIVERY ROOM	890.00	0.00
RESPIRATORY SERVICES	20,525.00	925.00
ANESTHESIA	68,900.00	3,156.00
GI SERVICES	86,340.30	15,847.00
EMERGENCY ROOM	734,062.00	1,130.00
RECOVERY ROOM	12,692.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,373.00	3,715.00
SPEECH PATHOLOGY	809.00	434.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,167.00	5,312.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	31,532.00	2,316.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,314.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,653.00	21,765.80
AUDIOLOGY	0.00	0.00
CARDIOLOGY	51,161.00	12,637.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,246.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,399.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,828.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	478,170.62	25,782.00
MRI SERVICES	66,149.00	7,313.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,276.35	15,274.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,002.00	7,081.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	2,615.00	0.00

TOTAL ANCILLARY	2,852,348.15	255,395.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,852,348.15	255,395.60

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5923143000151	04/03/23 - 04/03/23	05/29/23	2,615.00	0.00	0.00	0.00	692.21
TOTAL				2,615.00	0.00	0.00	0.00	692.21

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,034.30	ADJUSTMENTS	0.00
COVERED CHARGES	34,960.95	CONTRACTUAL ALLOW	26,899.60
NON-COVERD CHARGES	11,073.35	TOTAL MEDICAID LIAB	8,061.35
		LESS: COB	8,061.35
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.10	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	700.00	477.00
CT SCAN	1,830.00	4,299.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	825.00	0.00
IV THERAPY	1,297.00	364.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	219.00	0.00
ANESTHESIA	1,740.00	0.00
GI SERVICES	5,108.00	0.00
EMERGENCY ROOM	13,441.00	239.00
RECOVERY ROOM	474.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	685.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	4,152.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,014.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,599.00	853.00
MRI SERVICES	1,228.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	399.85	3.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,960.95	11,073.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,960.95	11,073.35

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	135,614.55	ADJUSTMENTS	469.92
COVERED CHARGES	128,393.50	CONTRACTUAL ALLOW	120,091.58
NON-COVERD CHARGES	7,221.05	TOTAL MEDICAID LIAB	8,301.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,301.92

TOTAL NUMBER OF CLAIMS 106

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157.25	206.25
MED/SURG SUPPLY	0.00	12.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,096.00	1,017.00
CT SCAN	24,029.00	2,783.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,300.00	0.00
IV THERAPY	6,819.00	432.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	438.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,548.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	146.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,467.00	969.00
MRI SERVICES	2,456.00	1,619.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,317.25	36.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	128,393.50	7,221.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	128,393.50	7,221.05

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,989.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,782.55	CONTRACTUAL ALLOW	6,312.63
NON-COVERD CHARGES	11,206.70	TOTAL MEDICAID LIAB	469.92
		LESS: COB	469.92
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.00	63.70
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	11,090.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	664.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,654.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,418.00	48.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44.55	5.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,782.55	11,206.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,782.55	11,206.70

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,244.90	ADJUSTMENTS	0.00
COVERED CHARGES	57,274.90	CONTRACTUAL ALLOW	47,064.68
NON-COVERD CHARGES	17,970.00	TOTAL MEDICAID LIAB	10,210.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,210.22

TOTAL NUMBER OF CLAIMS 2

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.40	250.00
MED/SURG SUPPLY	312.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	217.00	0.00
CT SCAN	13,316.00	0.00
PHYSICAL THERAPY	0.00	1,046.00
EKG/ECG	550.00	0.00
IV THERAPY	15,083.00	928.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	939.00	567.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,503.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,231.00
SPEECH PATHOLOGY	0.00	434.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	4,303.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,014.00	1,908.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,440.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,342.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,550.00	0.00
MRI SERVICES	0.00	5,303.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,919.50	2,000.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	57,274.90	17,970.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,274.90	17,970.00

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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PKWY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,730,992.01	ADJUSTMENTS	970,708.35
COVERED CHARGES	52,665,573.41	CONTRACTUAL ALLOW	47,101,790.11
NON-COVERD CHARGES	65,418.60	TOTAL MEDICAID LIAB	5,563,783.30
		LESS: COB	59,402.49
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,599.00
		REIMBURSEMENT	5,508,979.81

TOTAL NUMBER OF ADMISSIONS 560

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,344	0	3,237,696.00	0.00
ROUTINE NURSERY	145	0	411,820.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,489	0	3,649,516.00	0.00
SPECIAL CARE SERVICES				
CCU	913	0	6,456,736.00	0.00
ICU	613	0	4,934,016.00	0.00
NICU	51	0	577,422.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,577	0	11,968,174.00	0.00
TOTAL ACCOMODATIONS	3,066	0	15,617,690.00	0.00

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,577,060.90	123.10
MED/SURG SUPPLY	898,563.87	0.00
LABORATORY-GENERAL	7,519,087.00	786.00
RADIOLOGY-DIAGNOSTIC	821,074.00	0.00
CT SCAN	3,046,992.00	13,392.00
PHYSICAL THERAPY	87,170.00	0.00
EKG/ECG	445,312.00	0.00
IV THERAPY	719,495.00	1,185.00
OPERATING ROOM	2,456,453.43	0.00
LABOR/DELIVERY ROOM	630,068.00	0.00
RESPIRATORY SERVICES	5,128,421.00	0.00
ANESTHESIA	626,044.29	0.00
GI SERVICES	395,976.00	0.00
EMERGENCY ROOM	1,831,276.00	2,244.00
RECOVERY ROOM	158,026.00	0.00
LABORATORY PATHOLOGIC	201,211.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,718.00	0.00
SPEECH PATHOLOGY	112,070.00	0.00
RENAL DIALYSIS	0.00	24,705.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,880.00	0.00
PSYCHIATRIC SERVICES	13,134.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	161,097.00	9,629.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,131,677.00	10,635.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	140,964.40	1,679.40
AUDIOLOGY	0.00	0.00
CARDIOLOGY	939,619.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	56,015.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,983,758.57	1,040.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	450,713.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,090.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	408,831.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	57,085.95	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,047,883.41	65,418.60
TOTAL ACCOMODATIONS	15,617,690.00	0.00
TOTAL CHARGES	52,665,573.41	65,418.60

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	844,969.01	ADJUSTMENTS	0.00
COVERED CHARGES	840,028.01	CONTRACTUAL ALLOW	784,913.00
NON-COVERD CHARGES	4,941.00	TOTAL MEDICAID LIAB	55,115.01
		LESS: COB	55,178.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	29	0	69,861.00	0.00
ROUTINE NURSERY	1	0	1,356.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	30	0	71,217.00	0.00
SPECIAL CARE SERVICES				
CCU	10	0	70,720.00	0.00
ICU	6	0	47,736.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	16	0	118,456.00	0.00
TOTAL ACCOMODATIONS	46	0	189,673.00	0.00

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,849.00	0.00
MED/SURG SUPPLY	22,677.55	0.00
LABORATORY-GENERAL	110,012.00	0.00
RADIOLOGY-DIAGNOSTIC	8,593.00	0.00
CT SCAN	49,818.00	0.00
PHYSICAL THERAPY	2,209.00	0.00
EKG/ECG	5,488.00	0.00
IV THERAPY	10,532.00	0.00
OPERATING ROOM	81,468.00	0.00
LABOR/DELIVERY ROOM	57,445.00	0.00
RESPIRATORY SERVICES	23,030.00	0.00
ANESTHESIA	26,277.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,192.00	0.00
RECOVERY ROOM	7,408.00	0.00
LABORATORY PATHOLOGIC	1,491.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,270.00	0.00
SPEECH PATHOLOGY	1,625.00	0.00
RENAL DIALYSIS	0.00	4,941.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	161.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,554.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	38,734.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	57,259.48	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,525.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	330.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,830.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,576.98	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	650,355.01	4,941.00
TOTAL ACCOMODATIONS	189,673.00	0.00
TOTAL CHARGES	840,028.01	4,941.00

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,632,640.60	ADJUSTMENTS	178,625.72
COVERED CHARGES	19,526,738.09	CONTRACTUAL ALLOW	17,019,389.69
NON-COVERD CHARGES	1,105,902.51	TOTAL MEDICAID LIAB	2,507,348.40
		LESS: COB	14,278.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,493,070.17
		ALL OTHER	2,120,690.13
		FEE SCHEDULE-LAB	210,152.87
		INJECTABLE DRUGS	162,227.17

TOTAL NUMBER OF CLAIMS 3,614

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,393.73	0.00
MED/SURG SUPPLY	232,536.21	0.00
LABORATORY-GENERAL	0.00	68.40
RADIOLOGY-DIAGNOSTIC	735,902.00	1,191.00
CT SCAN	3,849,593.00	98,799.00
PHYSICAL THERAPY	45,185.00	10,239.00
EKG/ECG	340,574.00	6,272.00
IV THERAPY	1,128,050.00	40,389.00
OPERATING ROOM	805,219.19	232,420.81
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	191,405.00	0.00
ANESTHESIA	461,455.00	0.00
GI SERVICES	243,892.00	11,144.00
EMERGENCY ROOM	4,572,293.00	4,643.00
RECOVERY ROOM	135,474.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,450.00	1,194.00
SPEECH PATHOLOGY	630.00	6,439.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	846.00	3,220.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	455,391.10	31,988.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	79,989.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	227,215.60	15,807.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	279,860.00	52,327.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	166,741.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	680,536.34	326,267.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	276,824.00	11,946.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	101.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,639,553.90	69,409.38
MRI SERVICES	469,418.00	44,819.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,147,728.50	137,056.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	18,582.52	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	162.50

TOTAL ANCILLARY	19,526,738.09	1,105,902.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,526,738.09	1,105,902.51

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3036	5922278000601	09/07/22 - 09/07/22	10/10/22	0.00	162.50	0.00	0.00	0.00
TOTAL				0.00	162.50	0.00	0.00	0.00

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	399,384.36	ADJUSTMENTS	0.00
COVERED CHARGES	228,929.44	CONTRACTUAL ALLOW	200,288.26
NON-COVERD CHARGES	170,454.92	TOTAL MEDICAID LIAB	28,641.18
		LESS: COB	28,641.18
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 44

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,868.80	0.00
MED/SURG SUPPLY	12,996.71	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,792.00	0.00
CT SCAN	16,558.00	36,485.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,136.00	0.00
IV THERAPY	14,849.00	0.00
OPERATING ROOM	18,896.00	11,823.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	507.00	0.00
ANESTHESIA	13,533.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	63,946.00	0.00
RECOVERY ROOM	7,437.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,105.00	3,498.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	685.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,374.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,689.00	2,080.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,883.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	649.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,079.83	1,371.82
MRI SERVICES	7,190.00	4,681.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,404.10	109,867.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	228,929.44	170,454.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	228,929.44	170,454.92

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	407,956.50	ADJUSTMENTS	201.39
COVERED CHARGES	403,798.60	CONTRACTUAL ALLOW	394,870.31
NON-COVERD CHARGES	4,157.90	TOTAL MEDICAID LIAB	8,928.29
		LESS: COB	40.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,887.49

TOTAL NUMBER OF CLAIMS 133

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,162.80	0.00	OTHER LAB	8,131.00	0.00
MED/SURG SUPPLY	578.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,156.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,444.00	64.00
EKG/ECG	7,840.00	784.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,409.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,165.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,566.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,460.70	61.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	11,876.00	2,208.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,040.00			

TOTAL ANCILLARY	403,798.60	4,157.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	403,798.60	4,157.90

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,864.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,800.00	CONTRACTUAL ALLOW	3,598.61
NON-COVERD CHARGES	64.00	TOTAL MEDICAID LIAB	201.39
		LESS: COB	201.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	851.00	64.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,949.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,800.00	64.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,800.00	64.00

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	768,965.22	ADJUSTMENTS	0.00
COVERED CHARGES	747,999.82	CONTRACTUAL ALLOW	668,121.30
NON-COVERD CHARGES	20,965.40	TOTAL MEDICAID LIAB	79,878.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	79,878.52

TOTAL NUMBER OF CLAIMS 15

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,027.30	0.00
MED/SURG SUPPLY	43,800.07	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,050.00	0.00
CT SCAN	43,047.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,056.00	784.00
IV THERAPY	10,742.00	2,396.00
OPERATING ROOM	126,608.00	4,424.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	58,313.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,274.00	0.00
RECOVERY ROOM	14,273.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,483.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,452.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	47,566.00	5,771.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	35,302.47	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,516.00	1,624.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,673.00	165.00
MRI SERVICES	12,306.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	249,705.80	5,801.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	21,805.18	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	747,999.82	20,965.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	747,999.82	20,965.40

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,549.44	ADJUSTMENTS	0.00
COVERED CHARGES	68,370.04	CONTRACTUAL ALLOW	63,044.80
NON-COVERD CHARGES	179.40	TOTAL MEDICAID LIAB	5,325.24
		LESS: COB	5,325.24
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,052.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	313.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,073.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,427.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,352.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.60	179.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	68,370.04	179.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,370.04	179.40

** END OF REPORT **

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	143,926,598.04	ADJUSTMENTS	9,449,914.75
COVERED CHARGES	143,295,187.16	CONTRACTUAL ALLOW	112,256,186.14
NON-COVERD CHARGES	631,410.88	TOTAL MEDICAID LIAB	31,039,001.02
		LESS: COB	105,849.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	30,933,152.01

TOTAL NUMBER OF ADMISSIONS 1,729

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,328	0	9,516,464.00	0.00
ROUTINE NURSERY	1,385	0	4,143,268.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	10.00
TOTAL ROUTINE	7,713	0	13,659,732.00	10.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,798	0	13,199,182.00	0.00
NICU	123	0	672,822.00	0.00
PED ICU	937	0	4,632,834.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	131	0	584,522.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,989	0	19,089,360.00	0.00
TOTAL ACCOMODATIONS	12,702	0	32,749,092.00	10.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,921,508.37	0.00
MED/SURG SUPPLY	4,475,633.25	0.00
LABORATORY-GENERAL	20,110,783.41	0.00
RADIOLOGY-DIAGNOSTIC	2,798,055.74	0.00
CT SCAN	5,234,545.00	24,292.00
PHYSICAL THERAPY	770,983.50	0.00
EKG/ECG	688,163.00	0.00
IV THERAPY	1,121,384.00	0.00
OPERATING ROOM	8,135,007.00	10,700.00
LABOR/DELIVERY ROOM	533,920.00	0.00
RESPIRATORY SERVICES	11,303,721.30	0.00
ANESTHESIA	2,815,445.00	0.00
GI SERVICES	416,072.00	11,898.00
EMERGENCY ROOM	3,410,261.01	0.00
RECOVERY ROOM	606,879.00	0.00
LABORATORY PATHOLOGIC	1,053,929.52	0.00
RADIOLOGY THERAPEUTIC	160,005.00	0.00
OCCUPATIONAL THERAPY	636,990.50	0.00
SPEECH PATHOLOGY	420,433.00	0.00
RENAL DIALYSIS	467,744.00	29,987.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	857.00	23,397.00
PSYCHIATRIC SERVICES	30,192.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	958,868.00	7,151.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,636,291.50	31,180.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	97,688.00	822.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,020,128.18	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	840,055.00	0.00
ORGAN ACQUISITION	245,307.00	0.00
TREATMENT/OBSERV. RM	894,870.22	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,763,223.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,362.00	0.00
OTHER THERAPEUTIC SVC	228.00	14,364.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	946,877.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	608.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	37,986.36
INJECTABLE DRUGS	12,889,902.16	4,923.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	433,000.00
IMPL DEV CHARGE PATIENTS	4,137,174.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,700.00

TOTAL ANCILLARY	110,546,095.16	631,400.88
TOTAL ACCOMODATIONS	32,749,092.00	10.00
TOTAL CHARGES	143,295,187.16	631,410.88

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
873	5223127000015	02/20/23 - 03/12/23	05/15/23	0.00	850.00	0.00	0.00	0.00
874	5223127000015	02/20/23 - 03/12/23	05/15/23	0.00	850.00	0.00	0.00	0.00
TOTAL				0.00	1,700.00	0.00	0.00	0.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,076,017.27	ADJUSTMENTS	0.00
COVERED CHARGES	2,051,160.27	CONTRACTUAL ALLOW	1,763,075.43
NON-COVERD CHARGES	24,857.00	TOTAL MEDICAID LIAB	288,084.84
		LESS: COB	288,084.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	90	0	136,440.00	0.00
ROUTINE NURSERY	3	0	3,588.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	93	0	140,028.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	32	0	102,336.00	0.00
NICU	0	0	0.00	0.00
PED ICU	22	0	109,408.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	54	0	211,744.00	0.00
TOTAL ACCOMODATIONS	147	0	351,772.00	0.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194,194.20	0.00
MED/SURG SUPPLY	60,377.28	0.00
LABORATORY-GENERAL	172,251.52	0.00
RADIOLOGY-DIAGNOSTIC	30,048.00	0.00
CT SCAN	67,240.00	0.00
PHYSICAL THERAPY	5,936.00	0.00
EKG/ECG	3,670.00	0.00
IV THERAPY	18,081.00	0.00
OPERATING ROOM	157,548.00	1,916.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	194,214.29	0.00
ANESTHESIA	57,838.00	0.00
GI SERVICES	0.00	2,956.00
EMERGENCY ROOM	54,275.00	0.00
RECOVERY ROOM	20,475.00	0.00
LABORATORY PATHOLOGIC	11,412.00	0.00
RADIOLOGY THERAPEUTIC	1,455.00	0.00
OCCUPATIONAL THERAPY	4,866.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,749.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,412.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,958.00	17,431.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,625.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	150,263.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,488.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,307.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	35,210.00	805.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,074.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	339,346.98	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	46,823.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,699,388.27	24,857.00
TOTAL ACCOMODATIONS	351,772.00	0.00
TOTAL CHARGES	2,051,160.27	24,857.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	76,575,745.50	ADJUSTMENTS	1,219,542.86
COVERED CHARGES	69,535,159.45	CONTRACTUAL ALLOW	57,293,197.55
NON-COVERD CHARGES	7,040,586.05	TOTAL MEDICAID LIAB	12,241,961.90
		LESS: COB	29,946.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,212,015.87
		ALL OTHER	9,177,912.92
		FEE SCHEDULE-LAB	828,485.01
		INJECTABLE DRUGS	2,205,617.94

TOTAL NUMBER OF CLAIMS 26,130

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,739,275.49	9,282.94
MED/SURG SUPPLY	1,092,403.08	609.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,890,560.00	44,834.00
CT SCAN	3,564,232.00	983,132.00
PHYSICAL THERAPY	130,115.00	35,464.00
EKG/ECG	675,515.00	15,414.00
IV THERAPY	1,594,294.00	220,957.00
OPERATING ROOM	5,707,966.38	770,067.45
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	759,426.57	0.00
ANESTHESIA	1,735,966.00	0.00
GI SERVICES	652,607.09	391,651.83
EMERGENCY ROOM	6,721,916.68	19,799.00
RECOVERY ROOM	1,031,513.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,449,747.00	79,543.00
OCCUPATIONAL THERAPY	34,460.00	29,193.00
SPEECH PATHOLOGY	39,256.00	36,218.00
RENAL DIALYSIS	0.00	46,592.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,390,633.00	67,029.00
PSYCHIATRIC SERVICES	100,405.00	91.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,271,825.00	204,476.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	870,374.00	2,486.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	407,405.00	259,025.00
AUDIOLOGY	12,550.00	0.00
CARDIOLOGY	1,733,355.62	268,016.66
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	2,142.00
E E G	427,504.00	0.00
ORGAN ACQUISITION	0.00	2,837.00
TREATMENT/OBSERV. RM	849,940.04	41,586.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	928,784.20	5,118.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	36,528.00	22,556.00
OTHER THERAPEUTIC SVC	1,698.00	915.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,016,112.62	399,678.44
MRI SERVICES	1,736,417.00	259,042.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	269.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	29,575.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	598.20	996.79
INJECTABLE DRUGS	13,465,064.48	2,278,962.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	529,000.00
IMPL DEV CHARGE PATIENTS	437,137.00	8,733.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,869.00

TOTAL ANCILLARY	69,535,159.45	7,040,586.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,535,159.45	7,040,586.05

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
618	2022357041121	12/14/22 - 12/14/22	12/26/22	0.00	2,419.00	0.00	0.00	0.00
618	2023117082352	04/20/23 - 04/20/23	05/01/23	0.00	2,450.00	0.00	0.00	0.00
TOTAL				0.00	4,869.00	0.00	0.00	0.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,974,854.93	ADJUSTMENTS	0.00
COVERED CHARGES	821,550.79	CONTRACTUAL ALLOW	676,371.60
NON-COVERD CHARGES	1,153,304.14	TOTAL MEDICAID LIAB	145,179.19
		LESS: COB	145,179.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 270

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,342.28	7,881.57
MED/SURG SUPPLY	19,297.00	18,008.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,783.00	596.00
CT SCAN	13,500.00	23,852.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,707.00	367.00
IV THERAPY	20,553.00	5,182.00
OPERATING ROOM	148,405.78	78,617.22
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,274.00	958.00
ANESTHESIA	90,921.00	0.00
GI SERVICES	0.00	7,658.00
EMERGENCY ROOM	96,065.00	930.00
RECOVERY ROOM	66,590.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	24,189.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,394.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	18,556.00	665.00
PSYCHIATRIC SERVICES	622.00	182.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,644.00	11,506.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,723.00	3,682.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,799.00
AUDIOLOGY	2,379.00	0.00
CARDIOLOGY	27,785.40	111,472.92
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	24,794.00	48,858.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,656.00	1,496.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,756.00	5,138.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	90.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,523.54	18,395.78
MRI SERVICES	6,984.00	55,070.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47,500.79	576,835.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	172,670.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	821,550.79	1,153,304.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	821,550.79	1,153,304.14

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	726,342.55	ADJUSTMENTS	359.78
COVERED CHARGES	690,314.55	CONTRACTUAL ALLOW	663,664.55
NON-COVERD CHARGES	36,028.00	TOTAL MEDICAID LIAB	26,650.00
		LESS: COB	40.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	26,609.77

TOTAL NUMBER OF CLAIMS 447

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,285.20	0.00
MED/SURG SUPPLY	5,702.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,380.00	505.00
CT SCAN	35,990.00	14,080.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,973.00	0.00
IV THERAPY	28,001.00	2,413.00
OPERATING ROOM	1,132.00	4,826.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,479.00	0.00
ANESTHESIA	3,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	410,220.00	371.00
RECOVERY ROOM	3,323.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	855.00	298.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,631.00	1,647.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,742.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,676.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	180.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	96,794.61	2,265.00
MRI SERVICES	15,871.00	8,155.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,210.74	1,288.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	690,314.55	36,028.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	690,314.55	36,028.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,192.78	ADJUSTMENTS	0.00
COVERED CHARGES	53,843.78	CONTRACTUAL ALLOW	53,123.78
NON-COVERD CHARGES	2,349.00	TOTAL MEDICAID LIAB	720.00
		LESS: COB	720.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,185.20	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,028.00	0.00
CT SCAN	9,950.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	734.00	0.00
IV THERAPY	1,557.00	920.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,938.00	74.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	458.00	954.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,514.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,235.58	307.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	244.00	94.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	53,843.78	2,349.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,843.78	2,349.00

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,028,978.50	ADJUSTMENTS	263,133.94
COVERED CHARGES	24,953,925.23	CONTRACTUAL ALLOW	22,493,487.97
NON-COVERD CHARGES	2,075,053.27	TOTAL MEDICAID LIAB	2,460,437.26
		LESS: COB	4,360.46
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,456,076.80

TOTAL NUMBER OF CLAIMS 354

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334,864.68	7,770.39
MED/SURG SUPPLY	1,043,285.07	272,065.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,974.16	43,861.58
CT SCAN	61,126.00	22,444.00
PHYSICAL THERAPY	361.00	15,097.00
EKG/ECG	8,441.00	1,835.00
IV THERAPY	95,925.00	17,142.00
OPERATING ROOM	839,521.14	172,065.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,476.00	0.00
ANESTHESIA	300,637.00	0.00
GI SERVICES	44,781.80	7,562.20
EMERGENCY ROOM	45,701.00	0.00
RECOVERY ROOM	82,416.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	513,224.00	6,042.00
OCCUPATIONAL THERAPY	1,935.00	8,131.00
SPEECH PATHOLOGY	0.00	988.00
RENAL DIALYSIS	0.00	5,343.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,546.00	3,278.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,624.00	14,302.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,937.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,139.00	14,333.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	949,350.91	665,330.57
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,807.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,346.00	8,066.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,889.00	844.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	232.00	93.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	327,462.00	13,817.00
MRI SERVICES	3,317.00	4,500.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,554,852.47	743,142.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	27,000.00
IMPL DEV CHARGE PATIENTS	2,572,754.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,953,925.23	2,075,053.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,953,925.23	2,075,053.27

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

WELLSTAR MCG HALTH
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,073,857.69	ADJUSTMENTS	2,270,263.31
COVERED CHARGES	5,073,502.66	CONTRACTUAL ALLOW	2,569,044.66
NON-COVERD CHARGES	355.03	TOTAL MEDICAID LIAB	2,504,458.00
		LESS: COB	34,224.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,470,233.58

TOTAL NUMBER OF ADMISSIONS 94

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,436	0	2,005,391.80	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,436	0	2,005,391.80	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	12,235.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	12,235.00	0.00
TOTAL ACCOMODATIONS	1,441	0	2,017,626.80	0.00

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	669,276.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,991.70	262.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	449,026.61	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,380.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,106.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	585,086.99	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,550.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	454.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,431.83	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	129,795.61	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	641.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,021.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,959.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	979,432.15	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	127,847.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,772.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	82.40	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	92.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,055,875.86	355.03
TOTAL ACCOMODATIONS	2,017,626.80	0.00
TOTAL CHARGES	5,073,502.66	355.03

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/22	THROUGH	04/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,645,610.00	ADJUSTMENTS	58,762.95
COVERED CHARGES	1,617,702.78	CONTRACTUAL ALLOW	1,108,639.94
NON-COVERD CHARGES	27,907.22	TOTAL MEDICAID LIAB	509,062.84
		LESS: COB	10,894.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	498,168.10

TOTAL NUMBER OF ADMISSIONS 91

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	226	0	352,464.00	0.00
ROUTINE NURSERY	68	0	83,164.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	294	0	435,628.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	10	0	27,150.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	10	0	27,150.00	0.00
TOTAL ACCOMODATIONS	304	0	462,778.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	302,543.20	0.00
MED/SURG SUPPLY	94,675.68	30.00
LABORATORY-GENERAL	173,173.96	0.00
RADIOLOGY-DIAGNOSTIC	16,812.89	0.00
CT SCAN	52,497.13	12,277.42
PHYSICAL THERAPY	5,465.55	0.00
EKG/ECG	5,800.10	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	135,166.82	0.00
LABOR/DELIVERY ROOM	23,221.09	0.00
RESPIRATORY SERVICES	60,855.44	0.00
ANESTHESIA	34,553.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72,005.75	0.00
RECOVERY ROOM	7,484.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,180.20	0.00
SPEECH PATHOLOGY	784.40	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 SERVICE	9,561.77	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	26,317.76	15,045.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,113.64	554.40
AUDIOLOGY	4,439.90	0.00
CARDIOLOGY	21,704.42	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,782.31	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,080.51	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,090.55	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	788.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	72,046.03	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	11,779.78	0.00

TOTAL ANCILLARY	1,154,924.78	27,907.22
TOTAL ACCOMODATIONS	462,778.00	0.00
TOTAL CHARGES	1,617,702.78	27,907.22

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022244047918	08/17/22 - 08/26/22	09/05/22	8,870.99	0.00	0.00	0.00	0.00
614	2023013076195	12/14/22 - 01/04/23	01/16/23	2,908.79	0.00	0.00	0.00	0.00
TOTAL				11,779.78	0.00	0.00	0.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,913.79	ADJUSTMENTS	0.00
COVERED CHARGES	82,409.25	CONTRACTUAL ALLOW	54,749.31
NON-COVERD CHARGES	1,504.54	TOTAL MEDICAID LIAB	27,659.94
		LESS: COB	27,659.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	15	0	23,340.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	23,340.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	23,340.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,848.00	0.00
MED/SURG SUPPLY	3,648.44	0.00
LABORATORY-GENERAL	2,441.66	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	16,562.42	0.00
LABOR/DELIVERY ROOM	14,412.96	0.00
RESPIRATORY SERVICES	973.88	0.00
ANESTHESIA	9,409.71	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	575.71	0.00
LABORATORY PATHOLOGIC	331.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,068.40	1,504.54
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	797.06	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	59,069.25	1,504.54
TOTAL ACCOMODATIONS	23,340.00	0.00
TOTAL CHARGES	82,409.25	1,504.54

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,715,750.61	ADJUSTMENTS	219,019.50
COVERED CHARGES	2,444,740.90	CONTRACTUAL ALLOW	1,863,120.59
NON-COVERD CHARGES	271,009.71	TOTAL MEDICAID LIAB	581,620.31
		LESS: COB	2,097.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	579,523.22
		ALL OTHER	487,511.21
		FEE SCHEDULE-LAB	70,792.82
		INJECTABLE DRUGS	21,219.19

TOTAL NUMBER OF CLAIMS 1,584

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,028.20	19,357.65
MED/SURG SUPPLY	50,003.33	9,369.16
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101,051.16	5,842.65
CT SCAN	270,236.71	39,240.33
PHYSICAL THERAPY	8,656.48	3,758.22
EKG/ECG	20,658.90	324.90
IV THERAPY	17,687.56	935.48
OPERATING ROOM	163,404.39	28,881.27
LABOR/DELIVERY ROOM	7,572.88	2,257.69
RESPIRATORY SERVICES	41,440.14	3,360.12
ANESTHESIA	63,522.80	0.00
GI SERVICES	35,218.56	4,667.96
EMERGENCY ROOM	493,892.17	5,040.02
RECOVERY ROOM	33,103.29	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	106,346.62	31,813.72
OCCUPATIONAL THERAPY	393.40	0.00
SPEECH PATHOLOGY	587.70	274.66
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,451.87	1,397.95
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	146,974.59	7,084.17
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,206.70	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,301.18	21,250.77
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,119.90	3,360.27
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	97,017.59	1,553.90

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,073.43	3,596.48
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	393,156.38	10,460.85
MRI SERVICES	46,069.45	2,090.56
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	127,227.52	59,584.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	13,498.02	3,500.13
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	17,839.98	2,005.92

TOTAL ANCILLARY	2,444,740.90	271,009.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,444,740.90	271,009.71

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5922353000960	10/27/22 - 10/27/22	12/26/22	2,966.45	0.00	0.00	0.00	760.02
614	2222354009997	10/06/22 - 10/06/22	12/26/22	2,005.92	0.00	0.00	0.00	513.93
614	5923006000749	09/21/22 - 09/21/22	01/09/23	2,908.79	0.00	0.00	0.00	745.24
614	2223024009407	10/13/22 - 10/13/22	01/30/23	2,966.45	0.00	0.00	0.00	760.02
614	5923075001303	12/14/22 - 12/14/22	03/20/23	0.00	2,005.92	0.00	0.00	0.00
614	2223121002282	02/21/23 - 02/21/23	05/08/23	2,040.17	0.00	0.00	0.00	522.70
614	2223143007831	04/20/23 - 04/20/23	05/29/23	2,029.78	0.00	0.00	0.00	520.04
614	2223153007918	04/14/23 - 04/14/23	06/05/23	2,922.42	0.00	0.00	0.00	748.73
TOTAL				17,839.98	2,005.92	0.00	0.00	4,570.68

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,460.59	ADJUSTMENTS	0.00
COVERED CHARGES	51,683.22	CONTRACTUAL ALLOW	39,401.95
NON-COVERD CHARGES	12,777.37	TOTAL MEDICAID LIAB	12,281.27
		LESS: COB	12,281.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	833.70	731.50
MED/SURG SUPPLY	3,535.91	588.49
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,939.59	630.37
CT SCAN	1,275.00	6,060.78
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	374.20	0.00
IV THERAPY	587.55	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,128.92	564.41
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	332.24	0.00
GI SERVICES	1,697.12	0.00
EMERGENCY ROOM	12,002.42	0.00
RECOVERY ROOM	575.71	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,014.74	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	391.95	111.02
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,028.41	3,216.36
AUDIOLOGY	0.00	0.00
CARDIOLOGY	940.26	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/OBSERV. RM	13,946.20	183.36

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,770.75	654.88
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,308.55	36.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	51,683.22	12,777.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,683.22	12,777.37

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	197,334.64	ADJUSTMENTS	2,662.88
COVERED CHARGES	190,359.09	CONTRACTUAL ALLOW	179,785.89
NON-COVERD CHARGES	6,975.55	TOTAL MEDICAID LIAB	10,573.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,573.20

TOTAL NUMBER OF CLAIMS 135

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,525.60	577.50
MED/SURG SUPPLY	1,958.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,004.39	1,244.07
CT SCAN	37,357.52	1,155.48
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,432.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,217.35	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	97,879.20	1,042.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,177.80	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/OBSERV. RM	353.83	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	891.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,033.28	1,747.35
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,449.05	1,208.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	2,078.87	0.00

TOTAL ANCILLARY	190,359.09	6,975.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190,359.09	6,975.55

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5923024001261	10/11/22 - 10/11/22	01/30/23	2,078.87	0.00	0.00	0.00	0.00
TOTAL				2,078.87	0.00	0.00	0.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,114.15	ADJUSTMENTS	0.00
COVERED CHARGES	3,891.90	CONTRACTUAL ALLOW	3,735.26
NON-COVERD CHARGES	2,222.25	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	346.80	397.55
MED/SURG SUPPLY	142.96	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	1,706.31
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	187.10	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	399.68	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,905.72	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	873.44	82.19
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.20	36.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,891.90	2,222.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,891.90	2,222.25

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,384.18	ADJUSTMENTS	15,869.25
COVERED CHARGES	111,665.26	CONTRACTUAL ALLOW	95,796.01
NON-COVERD CHARGES	8,718.92	TOTAL MEDICAID LIAB	15,869.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,869.25

TOTAL NUMBER OF CLAIMS 3

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,769.80	654.80
MED/SURG SUPPLY	5,197.93	788.30
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	992.95	296.54
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,038.66
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	53,742.51	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	486.94	0.00
ANESTHESIA	13,038.32	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,050.98	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,273.93	59.52
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,093.10	2,340.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	31,018.80	3,540.30
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	111,665.26	8,718.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	111,665.26	8,718.92

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC
2000 DAN PROCTOR DR
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,896,089.83	ADJUSTMENTS	727,192.20
COVERED CHARGES	29,543,907.08	CONTRACTUAL ALLOW	21,981,209.79
NON-COVERD CHARGES	352,182.75	TOTAL MEDICAID LIAB	7,562,697.29
		LESS: COB	56,929.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,505,768.02

TOTAL NUMBER OF ADMISSIONS 867

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,296	0	7,502,762.00	0.00
ROUTINE NURSERY	266	0	345,158.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,562	0	7,847,920.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	590	0	1,548,824.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	590	0	1,548,824.00	0.00
TOTAL ACCOMODATIONS	5,152	0	9,396,744.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,285,765.01	0.00
MED/SURG SUPPLY	1,665,588.61	1,012.11
LABORATORY-GENERAL	2,851,096.29	0.00
RADIOLOGY-DIAGNOSTIC	421,445.41	0.00
CT SCAN	734,117.57	218,170.78
PHYSICAL THERAPY	145,508.88	0.00
EKG/ECG	112,875.78	0.00
IV THERAPY	2,467.00	0.00
OPERATING ROOM	2,247,655.74	0.00
LABOR/DELIVERY ROOM	192,100.29	0.00
RESPIRATORY SERVICES	1,745,156.47	0.00
ANESTHESIA	374,660.85	0.00
GI SERVICES	63,231.28	0.00
EMERGENCY ROOM	975,249.25	0.00
RECOVERY ROOM	106,437.04	0.00
LABORATORY PATHOLOGIC	4,262.49	0.00
RADIOLOGY THERAPEUTIC	64,789.72	0.00
OCCUPATIONAL THERAPY	137,565.26	0.00
SPEECH PATHOLOGY	33,798.55	0.00
RENAL DIALYSIS	437,962.35	7,552.55
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	302.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	152,476.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	346,599.25	102,308.72
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,729.52	22,147.11
AUDIOLOGY	17,759.60	0.00
CARDIOLOGY	886,078.18	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	45,140.99	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	187,104.08	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	102,982.03	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	344.40	0.00
OTHER THERAPEUTIC SVC	0.00	689.18
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	257,373.77	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47,642.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	381,935.80	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	66,262.92	0.00

TOTAL ANCILLARY	20,147,163.08	352,182.75
TOTAL ACCOMODATIONS	9,396,744.00	0.00
TOTAL CHARGES	29,543,907.08	352,182.75

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022139044659	05/06/22 - 05/12/22	05/23/22	2,922.42	0.00	0.00	0.00	0.00
614	2022167047450	06/06/22 - 06/10/22	06/20/22	2,040.17	0.00	0.00	0.00	0.00
615	2022171013912	06/10/22 - 06/14/22	06/27/22	2,093.57	0.00	0.00	0.00	0.00
614	2022213029957	07/12/22 - 07/15/22	08/08/22	2,922.42	0.00	0.00	0.00	0.00
614	2222224012358	07/10/22 - 07/16/22	08/15/22	2,922.42	0.00	0.00	0.00	0.00
614	5222227000402	06/21/22 - 07/05/22	08/22/22	2,966.45	0.00	0.00	0.00	0.00
614	2022235041362	08/08/22 - 08/17/22	08/29/22	2,040.17	0.00	0.00	0.00	0.00
614	2022241033855	06/01/22 - 06/13/22	09/05/22	2,040.17	0.00	0.00	0.00	0.00
614	2022262024651	08/05/22 - 09/13/22	09/26/22	2,966.45	0.00	0.00	0.00	0.00
614	2022290014005	06/25/22 - 06/30/22	10/24/22	2,005.92	0.00	0.00	0.00	0.00
615	2022311009838	10/26/22 - 10/31/22	11/14/22	4,153.73	0.00	0.00	0.00	0.00
614	2022321000068	10/06/22 - 10/29/22	11/21/22	2,078.87	0.00	0.00	0.00	0.00
614	2022336000033	11/19/22 - 11/26/22	12/05/22	2,078.87	0.00	0.00	0.00	0.00
614	2022347037598	11/29/22 - 12/08/22	12/19/22	2,966.45	0.00	0.00	0.00	0.00
614	5922349000429	11/22/22 - 11/26/22	12/19/22	2,078.87	0.00	0.00	0.00	0.00
614	2022364054239	12/19/22 - 12/23/22	01/02/23	2,922.42	0.00	0.00	0.00	0.00
615	2023032073149	08/03/22 - 09/06/22	02/06/23	2,093.57	0.00	0.00	0.00	0.00
614	5923040000218	12/30/22 - 01/10/23	02/13/23	2,966.45	0.00	0.00	0.00	0.00
615	2023061105817	02/14/23 - 02/24/23	03/06/23	5,133.44	0.00	0.00	0.00	0.00
614	2023076088595	03/03/23 - 03/09/23	03/20/23	2,981.10	0.00	0.00	0.00	0.00
614	2023079014403	03/11/23 - 03/14/23	03/27/23	2,899.35	0.00	0.00	0.00	0.00
614	2023082000014	03/11/23 - 03/17/23	03/27/23	1,104.63	0.00	0.00	0.00	0.00
614	2023100004577	03/31/23 - 04/03/23	04/17/23	2,922.42	0.00	0.00	0.00	0.00
614	2024012067111	01/19/23 - 02/07/23	01/15/24	2,040.17	0.00	0.00	0.00	0.00
614	2024051051210	10/25/22 - 11/04/22	02/26/24	2,922.42	0.00	0.00	0.00	0.00
TOTAL				66,262.92	0.00	0.00	0.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	299,562.49	ADJUSTMENTS	0.00
COVERED CHARGES	297,507.27	CONTRACTUAL ALLOW	207,244.44
NON-COVERD CHARGES	2,055.22	TOTAL MEDICAID LIAB	90,262.83
		LESS: COB	90,262.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	49	0	83,523.00	0.00
ROUTINE NURSERY	4	0	4,892.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	53	0	88,415.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	8	0	21,720.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	21,720.00	0.00
TOTAL ACCOMODATIONS	61	0	110,135.00	0.00

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,136.03	0.00
MED/SURG SUPPLY	11,365.76	0.00
LABORATORY-GENERAL	28,928.56	0.00
RADIOLOGY-DIAGNOSTIC	2,429.64	0.00
CT SCAN	2,836.72	2,055.22
PHYSICAL THERAPY	1,038.66	0.00
EKG/ECG	1,871.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	52,384.75	0.00
LABOR/DELIVERY ROOM	8,568.52	0.00
RESPIRATORY SERVICES	7,146.71	0.00
ANESTHESIA	10,669.42	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,951.97	0.00
RECOVERY ROOM	1,747.71	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	918.73	0.00
SPEECH PATHOLOGY	784.40	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 SERVICE	1,026.54	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,921.36	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	306.20	0.00
CARDIOLOGY	2,604.65	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	709.97	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,747.84	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,277.13	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	187,372.27	2,055.22
TOTAL ACCOMODATIONS	110,135.00	0.00
TOTAL CHARGES	297,507.27	2,055.22

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,323,096.72	ADJUSTMENTS	905,149.81
COVERED CHARGES	8,814,632.80	CONTRACTUAL ALLOW	6,605,729.87
NON-COVERD CHARGES	1,508,463.92	TOTAL MEDICAID LIAB	2,208,902.93
		LESS: COB	5,318.46
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,203,584.47
		ALL OTHER	1,586,053.03
		FEE SCHEDULE-LAB	207,990.25
		INJECTABLE DRUGS	409,541.19

TOTAL NUMBER OF CLAIMS 4,516

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227,273.03	93,212.45
MED/SURG SUPPLY	232,540.13	116,072.64
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	306,903.90	14,252.18
CT SCAN	847,716.78	81,102.79
PHYSICAL THERAPY	70,600.53	14,562.45
EKG/ECG	74,959.11	1,309.70
IV THERAPY	87,648.46	470.05
OPERATING ROOM	673,532.10	200,778.44
LABOR/DELIVERY ROOM	19,544.56	6,772.92
RESPIRATORY SERVICES	49,513.34	14,278.21
ANESTHESIA	203,189.15	0.00
GI SERVICES	90,150.66	15,341.36
EMERGENCY ROOM	1,360,757.93	18,814.31
RECOVERY ROOM	91,790.88	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	849,648.67	69,894.04
OCCUPATIONAL THERAPY	3,950.73	5,254.02
SPEECH PATHOLOGY	4,203.57	1,285.49
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	26,756.56	3,012.23
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	367,002.28	21,746.22
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	40,474.60	1,504.54
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,049.49	83,799.01
AUDIOLOGY	0.00	0.00
CARDIOLOGY	74,580.80	87,813.28
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,234.95	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	274,287.65	3,065.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	135,009.74	1,551.09
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	602.70
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,304,262.85	42,679.28
MRI SERVICES	151,409.14	5,137.79
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,063,971.65	583,516.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	35,480.26	16,608.71
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	90,189.30	4,026.22

TOTAL ANCILLARY	8,814,632.80	1,508,463.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,814,632.80	1,508,463.92

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2222180007808	06/09/22 - 06/09/22	07/04/22	2,922.42	0.00	0.00	0.00	737.62
614	2222182007521	06/14/22 - 06/14/22	07/04/22	2,005.92	0.00	0.00	0.00	506.30
614	2222203008256	06/29/22 - 06/29/22	07/25/22	2,005.92	0.00	0.00	0.00	506.30
614	2222258001070	05/19/22 - 05/19/22	09/19/22	2,005.92	0.00	0.00	0.00	490.36
614	2222264009990	06/07/22 - 06/07/22	09/26/22	2,078.87	0.00	0.00	0.00	508.19
614	2222266013758	06/06/22 - 06/06/22	10/03/22	2,005.92	0.00	0.00	0.00	490.36
614	5922271001017	06/22/22 - 06/22/22	10/03/22	2,966.45	0.00	0.00	0.00	725.17
614	5922318000389	06/03/22 - 06/03/22	11/21/22	2,005.92	0.00	0.00	0.00	490.36
614	5922320000606	09/14/22 - 09/14/22	11/21/22	2,005.92	0.00	0.00	0.00	490.36
614	2222336006838	11/18/22 - 11/18/22	12/05/22	1,996.44	0.00	0.00	0.00	488.04
614	2222336009138	11/04/22 - 11/04/22	12/05/22	2,922.42	0.00	0.00	0.00	714.41
614	2222341008435	08/24/22 - 08/24/22	12/12/22	1,996.44	0.00	0.00	0.00	488.04
614	2222343010475	11/21/22 - 11/21/22	12/12/22	1,996.44	0.00	0.00	0.00	488.04
614	2222347006832	08/23/22 - 08/23/22	12/19/22	2,922.42	0.00	0.00	0.00	714.41
614	2222350008353	08/29/22 - 08/29/22	12/19/22	1,996.44	0.00	0.00	0.00	488.04
614	2222354006429	12/01/22 - 12/01/22	12/26/22	2,922.42	0.00	0.00	0.00	714.41
614	2222354009772	09/14/22 - 09/14/22	12/26/22	2,005.92	0.00	0.00	0.00	490.36
614	2222354009886	10/11/22 - 10/11/22	12/26/22	2,005.92	0.00	0.00	0.00	490.36
614	2222355006541	09/06/22 - 09/06/22	12/26/22	2,040.17	0.00	0.00	0.00	498.74
614	2222363003174	09/14/22 - 09/14/22	01/02/23	2,922.42	0.00	0.00	0.00	714.41
614	5923005000567	12/02/22 - 12/02/22	01/09/23	2,922.42	0.00	0.00	0.00	714.41
614	2223005006051	11/28/22 - 11/28/22	01/09/23	2,005.92	0.00	0.00	0.00	490.36
614	2223010009248	12/09/22 - 12/09/22	01/16/23	2,005.92	0.00	0.00	0.00	490.36
614	2223018005482	12/30/22 - 12/30/22	01/23/23	2,040.17	0.00	0.00	0.00	498.74
614	5923025001138	12/16/22 - 12/16/22	01/30/23	2,922.42	0.00	0.00	0.00	714.41
614	2223027004069	10/25/22 - 10/25/22	01/30/23	2,922.42	0.00	0.00	0.00	714.41
614	2223027009481	12/12/22 - 12/12/22	01/30/23	1,996.44	0.00	0.00	0.00	488.04
614	5923053000878	01/30/23 - 01/30/23	02/27/23	1,996.44	0.00	0.00	0.00	488.04
614	2223068013532	01/19/23 - 01/19/23	03/13/23	2,922.42	0.00	0.00	0.00	714.41
614	2223076010683	02/27/23 - 02/27/23	03/20/23	2,078.87	0.00	0.00	0.00	508.19
614	5923082000573	02/15/23 - 02/15/23	03/27/23	0.00	2,029.78	0.00	0.00	0.00
614	5923115000866	03/28/23 - 03/28/23	05/01/23	2,922.42	0.00	0.00	0.00	714.41
614	2223124000731	03/09/23 - 03/09/23	05/08/23	1,996.44	0.00	0.00	0.00	488.04
614	2223124000751	03/20/23 - 03/20/23	05/08/23	1,996.44	0.00	0.00	0.00	488.04
614	2223124004635	03/03/23 - 03/03/23	05/08/23	2,922.42	0.00	0.00	0.00	714.41
614	2223125009894	03/27/23 - 03/27/23	05/08/23	2,922.42	0.00	0.00	0.00	714.41
614	5923167000308	04/28/23 - 04/28/23	06/19/23	0.00	1,996.44	0.00	0.00	0.00
614	5923179000690	01/10/23 - 01/10/23	07/03/23	2,922.42	0.00	0.00	0.00	714.41
614	5923187001079	03/24/23 - 03/24/23	07/10/23	2,922.42	0.00	0.00	0.00	714.41
614	2223198000620	03/21/23 - 03/21/23	07/24/23	2,040.17	0.00	0.00	0.00	498.74
TOTAL				90,189.30	4,026.22	0.00	0.00	22,102.52

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	349,198.86	ADJUSTMENTS	0.00
COVERED CHARGES	164,165.02	CONTRACTUAL ALLOW	128,313.20
NON-COVERD CHARGES	185,033.84	TOTAL MEDICAID LIAB	35,851.82
		LESS: COB	35,851.82
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 65

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,541.30	89,934.95
MED/SURG SUPPLY	3,836.00	5,296.81
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,181.84	1,768.44
CT SCAN	0.00	4,955.41
PHYSICAL THERAPY	3,034.39	1,253.35
EKG/ECG	1,683.90	0.00
IV THERAPY	16,176.40	0.00
OPERATING ROOM	3,264.49	29,634.39
LABOR/DELIVERY ROOM	0.00	564.41
RESPIRATORY SERVICES	1,363.40	1,060.26
ANESTHESIA	10,059.12	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,659.42	0.00
RECOVERY ROOM	2,947.12	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	22,097.78	1,192.20
OCCUPATIONAL THERAPY	0.00	1,053.05
SPEECH PATHOLOGY	0.00	274.66
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	415.63	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,809.11	9,802.61
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	3,000.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,190.08	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,437.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,071.94	2,174.80
MRI SERVICES	0.00	6,042.94
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,395.60	26,194.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	831.36
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	164,165.02	185,033.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	164,165.02	185,033.84

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	497,590.78	ADJUSTMENTS	6,713.00
COVERED CHARGES	472,179.77	CONTRACTUAL ALLOW	451,369.47
NON-COVERD CHARGES	25,411.01	TOTAL MEDICAID LIAB	20,810.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	20,810.30

TOTAL NUMBER OF CLAIMS 310

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,328.25	1,815.85
MED/SURG SUPPLY	6,939.64	425.63
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,964.14	1,132.91
CT SCAN	103,108.04	12,951.12
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,864.60	0.00
IV THERAPY	232.68	0.00
OPERATING ROOM	6,050.96	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,412.11	0.00
ANESTHESIA	766.38	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	227,440.05	1,429.11
RECOVERY ROOM	342.68	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	875.57	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	604.60	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,567.96	853.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,037.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	55,983.62	2,611.18
MRI SERVICES	8,971.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,689.35	3,904.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	287.73
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	472,179.77	25,411.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	472,179.77	25,411.01

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,335.37	ADJUSTMENTS	0.00
COVERED CHARGES	9,743.52	CONTRACTUAL ALLOW	9,139.35
NON-COVERD CHARGES	1,591.85	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	238.95	13.60
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	489.75	0.00
CT SCAN	0.00	1,130.41
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	187.10	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	5,885.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	338.85
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,870.31	108.99
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,743.52	1,591.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,743.52	1,591.85

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,460,712.19	ADJUSTMENTS	269,777.25
COVERED CHARGES	3,166,226.60	CONTRACTUAL ALLOW	2,695,438.85
NON-COVERD CHARGES	294,485.59	TOTAL MEDICAID LIAB	470,787.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	470,787.75

TOTAL NUMBER OF CLAIMS 89

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,512.29	20,031.05
MED/SURG SUPPLY	97,313.26	44,672.81
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,906.05	237.51
CT SCAN	2,223.28	0.00
PHYSICAL THERAPY	766.41	4,588.43
EKG/ECG	2,058.10	0.00
IV THERAPY	23,407.91	0.00
OPERATING ROOM	745,459.29	4,906.70
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,165.11	0.00
ANESTHESIA	74,992.33	2,173.14
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	15,791.17	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	286,036.08	3,996.78
OCCUPATIONAL THERAPY	0.00	8,101.56
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	513.27	897.13
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,146.07	3,100.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	75,331.02	33,488.04
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	30,844.54	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,342.07	932.27
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,435,585.96	74,975.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	256,832.39	92,383.58
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,166,226.60	294,485.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,166,226.60	294,485.59

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,353.33	ADJUSTMENTS	0.00
COVERED CHARGES	30,718.14	CONTRACTUAL ALLOW	25,428.39
NON-COVERD CHARGES	20,635.19	TOTAL MEDICAID LIAB	5,289.75
		LESS: COB	5,289.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

SOUTHEAST GEORGIA HEALTH SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	479.15	2,741.30	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	822.17	2,915.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	299.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	450.97	FEE SCHEDULE LAB	131.09	35.66
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,120.53	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,643.68	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	856.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,122.00	693.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	868.34	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,929.39
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	30,718.14	20,635.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,718.14	20,635.19

** END OF REPORT **

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,308,508.80	ADJUSTMENTS	0.00
COVERED CHARGES	1,308,508.80	CONTRACTUAL ALLOW	818,633.22
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	489,875.58
		LESS: COB	4,949.35
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	49,079.00
		REIMBURSEMENT	534,005.23

TOTAL NUMBER OF ADMISSIONS 132

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	217	0	217,458.00	0.00
ROUTINE NURSERY	83	0	64,235.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	300	0	281,693.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	21,357.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	21,357.00	0.00
TOTAL ACCOMODATIONS	309	0	303,050.00	0.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,314.80	0.00
MED/SURG SUPPLY	71,471.00	0.00
LABORATORY-GENERAL	232,314.00	0.00
RADIOLOGY-DIAGNOSTIC	17,775.00	0.00
CT SCAN	39,487.00	0.00
PHYSICAL THERAPY	11,652.00	0.00
EKG/ECG	5,520.00	0.00
IV THERAPY	6,930.00	0.00
OPERATING ROOM	92,061.00	0.00
LABOR/DELIVERY ROOM	126,136.00	0.00
RESPIRATORY SERVICES	22,969.00	0.00
ANESTHESIA	4,992.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	50,232.00	0.00
RECOVERY ROOM	8,349.00	0.00
LABORATORY PATHOLOGIC	9,708.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,744.00	0.00
SPEECH PATHOLOGY	1,964.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,200.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,840.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	38,928.00	0.00
CARDIOLOGY	14,779.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,713.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,330.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,050.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,005,458.80	0.00
TOTAL ACCOMODATIONS	303,050.00	0.00
TOTAL CHARGES	1,308,508.80	0.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,704,431.30	ADJUSTMENTS	66,570.84
COVERED CHARGES	2,582,938.41	CONTRACTUAL ALLOW	2,022,530.31
NON-COVERD CHARGES	121,492.89	TOTAL MEDICAID LIAB	560,408.10
		LESS: COB	1,107.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	559,300.73
		ALL OTHER	484,747.40
		FEE SCHEDULE-LAB	69,178.91
		INJECTABLE DRUGS	5,374.42

TOTAL NUMBER OF CLAIMS 1,961

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,118.00	4,865.00
MED/SURG SUPPLY	49,883.00	48.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,517.00	702.00
CT SCAN	411,345.00	29,393.00
PHYSICAL THERAPY	68,721.00	6,440.00
EKG/ECG	31,244.00	230.00
IV THERAPY	166,506.00	2,713.00
OPERATING ROOM	138,839.11	7,095.89
LABOR/DELIVERY ROOM	2,250.00	0.00
RESPIRATORY SERVICES	25,312.00	6,781.00
ANESTHESIA	22,356.00	0.00
GI SERVICES	29,721.00	4,863.00
EMERGENCY ROOM	454,679.00	388.00
RECOVERY ROOM	25,251.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	38,982.00	2,899.00
SPEECH PATHOLOGY	714.00	710.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,024.00	904.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	42,317.00	1,828.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,008.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,244.00	0.00
CARDIOLOGY	17,465.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	36,200.00	5,994.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,288.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	627,554.30	27,768.00
MRI SERVICES	121,087.00	6,100.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,011.00	9,171.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	12,302.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,600.00

TOTAL ANCILLARY	2,582,938.41	121,492.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,582,938.41	121,492.89

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
948	2023192051502	07/05/23 - 07/05/23	07/17/23	0.00	100.00	0.00	0.00	0.00
948	2023194075966	07/07/23 - 07/07/23	07/17/23	0.00	100.00	0.00	0.00	0.00
948	2023198026042	07/11/23 - 07/11/23	07/24/23	0.00	200.00	0.00	0.00	0.00
948	2023200071724	07/13/23 - 07/13/23	07/24/23	0.00	100.00	0.00	0.00	0.00
948	2023205023493	07/18/23 - 07/18/23	07/31/23	0.00	200.00	0.00	0.00	0.00
948	2023208038131	07/20/23 - 07/20/23	07/31/23	0.00	100.00	0.00	0.00	0.00
948	2023214073050	07/27/23 - 07/27/23	08/07/23	0.00	100.00	0.00	0.00	0.00
948	2023221072071	08/03/23 - 08/03/23	08/14/23	0.00	100.00	0.00	0.00	0.00
948	2023229074093	08/10/23 - 08/10/23	08/21/23	0.00	200.00	0.00	0.00	0.00
948	2023235062753	08/17/23 - 08/17/23	08/28/23	0.00	200.00	0.00	0.00	0.00
948	2023240030873	08/22/23 - 08/22/23	09/04/23	0.00	200.00	0.00	0.00	0.00
948	5923278000714	08/01/23 - 08/01/23	10/09/23	0.00	100.00	0.00	0.00	0.00
948	5923279001015	08/15/23 - 08/15/23	10/09/23	0.00	100.00	0.00	0.00	0.00
948	5923284001832	09/21/23 - 09/21/23	10/16/23	0.00	200.00	0.00	0.00	0.00
948	5923284001836	09/19/23 - 09/19/23	10/16/23	0.00	200.00	0.00	0.00	0.00
948	5923289001438	09/26/23 - 09/26/23	10/23/23	0.00	200.00	0.00	0.00	0.00
948	5923289001439	09/28/23 - 09/28/23	10/23/23	0.00	200.00	0.00	0.00	0.00
TOTAL				0.00	2,600.00	0.00	0.00	0.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,632.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,515.00	CONTRACTUAL ALLOW	25,401.14
NON-COVERD CHARGES	8,117.00	TOTAL MEDICAID LIAB	7,113.86
		LESS: COB	7,113.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123.00	53.00
MED/SURG SUPPLY	254.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,948.00	486.00
CT SCAN	4,210.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	230.00	0.00
IV THERAPY	7,489.00	5,018.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	750.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	364.00	0.00
GI SERVICES	0.00	1,701.00
EMERGENCY ROOM	3,315.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,779.00	632.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,125.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,332.00	227.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,596.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	32,515.00	8,117.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,515.00	8,117.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	89,303.00	ADJUSTMENTS	0.00
COVERED CHARGES	87,724.00	CONTRACTUAL ALLOW	80,675.20
NON-COVERD CHARGES	1,579.00	TOTAL MEDICAID LIAB	7,048.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,048.80

TOTAL NUMBER OF CLAIMS 90

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	524.00	269.00
MED/SURG SUPPLY	628.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,456.00	0.00
CT SCAN	6,193.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,150.00	0.00
IV THERAPY	4,820.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,890.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,107.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,169.00	1,227.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,787.00	83.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	87,724.00	1,579.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,724.00	1,579.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,885.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,527.00	CONTRACTUAL ALLOW	4,292.04
NON-COVERD CHARGES	4,358.00	TOTAL MEDICAID LIAB	234.96
		LESS: COB	234.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24.00	0.00
MED/SURG SUPPLY	110.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	3,726.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	518.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,986.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	632.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,794.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	95.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,527.00	4,358.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,527.00	4,358.00

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	116,030.00	ADJUSTMENTS	0.00
COVERED CHARGES	104,813.96	CONTRACTUAL ALLOW	83,810.74
NON-COVERD CHARGES	11,216.04	TOTAL MEDICAID LIAB	21,003.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,003.22

TOTAL NUMBER OF CLAIMS 4

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,178.00	0.00
MED/SURG SUPPLY	8,487.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	230.00	0.00
IV THERAPY	21,427.00	0.00
OPERATING ROOM	46,963.96	4,916.04
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	305.00	0.00
ANESTHESIA	2,262.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	844.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	6,290.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,258.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,883.00	10.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	8,590.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	104,813.96	11,216.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	104,813.96	11,216.04

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/23	THROUGH	12/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	587,387,006.64	ADJUSTMENTS	20,785,026.70
COVERED CHARGES	586,132,763.53	CONTRACTUAL ALLOW	500,098,879.58
NON-COVERD CHARGES	1,254,243.11	TOTAL MEDICAID LIAB	86,033,883.95
		LESS: COB	1,118,573.89
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	72,453.48
		REIMBURSEMENT	84,987,763.54

TOTAL NUMBER OF ADMISSIONS 5,533

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	26,452	0	73,690,706.00	0.00
ROUTINE NURSERY	4,043	0	15,579,698.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	326,578.51
TOTAL ROUTINE	30,495	0	89,270,404.50	326,578.51
SPECIAL CARE SERVICES				
CCU	321	0	1,645,988.00	0.00
ICU	8,332	0	47,057,620.00	0.00
NICU	132	0	939,840.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	505	0	5,177,298.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9,290	0	54,820,746.00	0.00
TOTAL ACCOMODATIONS	39,785	0	144,091,150.50	326,578.51

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,496,188.07	78,366.10
MED/SURG SUPPLY	10,789,118.07	1,635.60
LABORATORY-GENERAL	71,182,177.62	0.00
RADIOLOGY-DIAGNOSTIC	10,583,494.00	0.00
CT SCAN	44,447,477.00	0.00
PHYSICAL THERAPY	4,487,496.50	0.00
EKG/ECG	4,844,164.00	0.00
IV THERAPY	9,236,689.00	0.00
OPERATING ROOM	103,299,167.75	40,416.00
LABOR/DELIVERY ROOM	2,678,442.00	18,576.00
RESPIRATORY SERVICES	40,920,842.00	0.00
ANESTHESIA	18,375,636.00	0.00
GI SERVICES	916,170.00	0.00
EMERGENCY ROOM	33,294,944.00	0.00
RECOVERY ROOM	10,124,532.00	0.00
LABORATORY PATHOLOGIC	987,826.50	2,482.00
RADIOLOGY THERAPEUTIC	832,921.00	0.00
OCCUPATIONAL THERAPY	3,279,449.50	0.00
SPEECH PATHOLOGY	1,339,271.00	0.00
RENAL DIALYSIS	2,459,655.00	72,567.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,288.00	148,767.80
PSYCHIATRIC SERVICES	55,303.92	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,111,626.50	157,192.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,931,883.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	580,410.00	131,423.00
AUDIOLOGY	285,614.00	0.00
CARDIOLOGY	7,695,550.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,495,280.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,862,491.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,804,758.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	443,500.00	0.00
OTHER THERAPEUTIC SVC	0.00	11,529.00
SPECIAL CHARGES	25,848.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,483,715.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	63.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	13,122.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	263,230.03
INJECTABLE DRUGS	16,736,164.48	341.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	100.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,926,496.62	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,901.00	976.00

TOTAL ANCILLARY	442,041,613.03	927,664.60
TOTAL ACCOMODATIONS	144,091,150.50	326,578.51
TOTAL CHARGES	586,132,763.53	1,254,243.11

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023096030586	03/29/23 - 04/01/23	04/10/23	0.00	122.00	0.00	0.00	0.00
780	2023153032681	05/25/23 - 05/26/23	06/05/23	0.00	122.00	0.00	0.00	0.00
780	2323159000296	03/24/23 - 03/29/23	06/12/23	0.00	122.00	0.00	2,697.91	0.00
780	2123194000041	04/15/23 - 04/17/23	09/04/23	0.00	122.00	0.00	0.00	0.00
780	2023228052096	08/05/23 - 08/13/23	08/21/23	0.00	122.00	0.00	0.00	0.00
780	2023284029075	09/25/23 - 10/06/23	10/16/23	0.00	122.00	0.00	0.00	0.00
780	2023318025731	11/05/23 - 11/10/23	11/20/23	0.00	122.00	0.00	0.00	0.00
614	2324016000313	10/23/23 - 11/30/23	02/12/24	4,901.00	0.00	0.00	1,510.49	0.00
780	2024194037018	07/17/23 - 07/21/23	07/15/24	0.00	122.00	0.00	0.00	0.00
TOTAL				4,901.00	976.00	0.00	4,208.40	0.00

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,204,015.32	ADJUSTMENTS	0.00
COVERED CHARGES	10,180,372.86	CONTRACTUAL ALLOW	8,652,232.11
NON-COVERD CHARGES	23,642.46	TOTAL MEDICAID LIAB	1,528,140.75
		LESS: COB	1,529,211.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,071.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 130

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	407	0	1,162,444.00	0.00
ROUTINE NURSERY	82	0	345,757.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.01
TOTAL ROUTINE	489	0	1,508,201.00	0.01
SPECIAL CARE SERVICES				
CCU	8	0	40,648.00	0.00
ICU	115	0	633,880.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	123	0	674,528.00	0.00
TOTAL ACCOMODATIONS	612	0	2,182,729.00	0.01

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,866.34	15,100.04
MED/SURG SUPPLY	138,630.03	0.00
LABORATORY-GENERAL	1,208,181.86	0.00
RADIOLOGY-DIAGNOSTIC	215,587.00	0.00
CT SCAN	920,322.00	0.00
PHYSICAL THERAPY	63,845.00	0.00
EKG/ECG	89,229.00	0.00
IV THERAPY	147,438.00	0.00
OPERATING ROOM	1,877,041.00	0.00
LABOR/DELIVERY ROOM	141,054.00	0.00
RESPIRATORY SERVICES	492,817.00	0.00
ANESTHESIA	430,050.00	0.00
GI SERVICES	13,237.00	0.00
EMERGENCY ROOM	670,568.00	0.00
RECOVERY ROOM	291,246.00	0.00
LABORATORY PATHOLOGIC	19,487.00	0.00
RADIOLOGY THERAPEUTIC	36,477.00	0.00
OCCUPATIONAL THERAPY	40,892.00	0.00
SPEECH PATHOLOGY	10,104.00	0.00
RENAL DIALYSIS	19,701.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	23,643.00	5,419.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	75,594.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,717.00	1,673.00
AUDIOLOGY	6,565.00	0.00
CARDIOLOGY	202,862.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	40,241.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,465.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	92,130.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,816.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	264.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	144,615.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,450.41
INJECTABLE DRUGS	336,669.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	88,289.45	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,997,643.86	23,642.45
TOTAL ACCOMODATIONS	2,182,729.00	0.01
TOTAL CHARGES	10,180,372.86	23,642.46

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	192,508,171.84	ADJUSTMENTS	1,484,779.07
COVERED CHARGES	175,268,261.29	CONTRACTUAL ALLOW	148,197,492.88
NON-COVERD CHARGES	17,239,910.55	TOTAL MEDICAID LIAB	27,070,768.41
		LESS: COB	233,371.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	26,837,396.88
		ALL OTHER	20,586,226.12
		FEE SCHEDULE-LAB	1,572,147.33
		INJECTABLE DRUGS	4,679,023.43

TOTAL NUMBER OF CLAIMS 56,001

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
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GRADY MEMORIAL HOSPITAL
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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	656,417.02	893.85
MED/SURG SUPPLY	761,608.06	64,545.86
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,381,876.00	114,895.00
CT SCAN	20,377,309.00	2,991,126.00
PHYSICAL THERAPY	1,323,285.00	137,997.00
EKG/ECG	2,512,980.00	56,451.00
IV THERAPY	6,375,682.00	704,316.00
OPERATING ROOM	9,323,141.26	3,290,015.74
LABOR/DELIVERY ROOM	9,288.00	0.00
RESPIRATORY SERVICES	923,409.00	67,634.00
ANESTHESIA	3,194,346.00	2,077.00
GI SERVICES	1,961,490.29	302,130.71
EMERGENCY ROOM	32,292,637.00	376,409.00
RECOVERY ROOM	1,360,711.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	7,762,861.00	340,720.00
OCCUPATIONAL THERAPY	119,346.00	66,314.00
SPEECH PATHOLOGY	19,460.00	22,264.00
RENAL DIALYSIS	0.00	22,902.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,374,213.51	684,983.77
PSYCHIATRIC SERVICES	521,174.00	15,142.06
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,652,623.00	507,340.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,717,595.00	27,530.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,455,499.00	527,587.00
AUDIOLOGY	58,403.00	21,502.00
CARDIOLOGY	1,730,715.00	356,072.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	46,882.00	887.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,928,051.00	224,670.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,465,575.00	43,134.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	10,165.00
OTHER THERAPEUTIC SVC	0.00	2,497.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	34,998,424.40	1,380,816.75
MRI SERVICES	2,503,401.00	621,112.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	35,415.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	54,105.37
INJECTABLE DRUGS	15,274,897.10	4,078,441.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.08
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	107,818.65	123,233.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	41,728.00	0.00

TOTAL ANCILLARY	175,268,261.29	17,239,910.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	175,268,261.29	17,239,910.55

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023010024694	01/05/23 - 01/05/23	01/16/23	122.00	0.00	0.00	0.00	20.52
780	2023027039756	01/04/23 - 01/04/23	01/30/23	122.00	0.00	0.00	0.00	20.52
780	2023027039760	01/06/23 - 01/06/23	01/30/23	122.00	0.00	0.00	0.00	20.52
780	2023033036014	01/13/23 - 01/13/23	02/06/23	122.00	0.00	0.00	0.00	20.52
780	2023035030504	01/30/23 - 01/30/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023035030641	01/30/23 - 01/30/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023037005726	02/01/23 - 02/01/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023037005763	02/01/23 - 02/01/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023037005832	02/01/23 - 02/01/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023038021974	01/30/23 - 01/30/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023038023274	01/23/23 - 01/23/23	02/13/23	122.00	0.00	0.00	0.00	20.52
780	2023042026784	02/06/23 - 02/06/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023042027334	02/06/23 - 02/06/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023042027399	02/06/23 - 02/06/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023044006129	02/08/23 - 02/08/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023044006314	02/08/23 - 02/08/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023048036310	02/01/23 - 02/01/23	02/20/23	122.00	0.00	0.00	0.00	20.52
780	2023051002801	02/15/23 - 02/15/23	02/27/23	122.00	0.00	0.00	0.00	20.52
780	2023059031323	02/23/23 - 02/23/23	03/06/23	122.00	0.00	0.00	0.00	20.52
780	2023066046483	03/02/23 - 03/02/23	03/13/23	122.00	0.00	0.00	0.00	20.52
780	2023066046775	02/27/23 - 02/27/23	03/13/23	122.00	0.00	0.00	0.00	20.52
780	2023067045883	03/02/23 - 03/02/23	03/13/23	122.00	0.00	0.00	0.00	20.52
780	2023073027514	03/09/23 - 03/09/23	03/20/23	122.00	0.00	0.00	0.00	20.52
780	2023074026081	03/06/23 - 03/06/23	03/20/23	122.00	0.00	0.00	0.00	20.52
780	2023077023462	02/06/23 - 02/06/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023080040572	03/10/23 - 03/10/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029154	01/17/23 - 01/17/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029425	01/23/23 - 01/23/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029430	02/02/23 - 02/02/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029431	01/25/23 - 01/25/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029466	01/20/23 - 01/20/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082029473	01/11/23 - 01/11/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082039207	02/06/23 - 02/06/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082039792	02/15/23 - 02/15/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082040281	01/25/23 - 01/25/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082040285	01/18/23 - 01/18/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082040716	01/06/23 - 01/06/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082040748	01/31/23 - 01/31/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082040754	02/13/23 - 02/13/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082042704	02/08/23 - 02/08/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023082042757	01/24/23 - 01/24/23	03/27/23	122.00	0.00	0.00	0.00	20.52
780	2023085003424	03/21/23 - 03/21/23	04/03/23	122.00	0.00	0.00	0.00	20.52

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

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SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	2023091033820	03/27/23 - 03/27/23	04/10/23	122.00	0.00	0.00	0.00	20.52
780	2023091033989	03/27/23 - 03/27/23	04/10/23	122.00	0.00	0.00	0.00	20.52
780	2223096010919	02/20/23 - 02/20/23	04/10/23	122.00	0.00	0.00	0.00	20.52
780	2023100016088	04/05/23 - 04/05/23	04/17/23	122.00	0.00	0.00	0.00	20.52
780	2023101024017	04/06/23 - 04/06/23	04/17/23	122.00	0.00	0.00	0.00	20.52
780	2023110033947	04/06/23 - 04/06/23	04/24/23	122.00	0.00	0.00	0.00	20.52
780	2023112019273	04/17/23 - 04/17/23	05/01/23	122.00	0.00	0.00	0.00	20.52
780	2023114010816	04/19/23 - 04/19/23	05/01/23	122.00	0.00	0.00	0.00	20.52
780	2023117027788	04/21/23 - 04/21/23	05/01/23	122.00	0.00	0.00	0.00	20.52
780	2023118036039	03/23/23 - 03/23/23	05/01/23	122.00	0.00	0.00	0.00	20.52
780	2023120002499	04/25/23 - 04/25/23	05/08/23	122.00	0.00	0.00	0.00	20.52
780	2023120002521	04/25/23 - 04/25/23	05/08/23	122.00	0.00	0.00	0.00	20.52
780	2023121016291	04/26/23 - 04/26/23	05/08/23	122.00	0.00	0.00	0.00	20.52
780	2023124029153	03/28/23 - 03/28/23	05/08/23	122.00	0.00	0.00	0.00	20.52
780	2023124029578	03/24/23 - 03/24/23	05/08/23	122.00	0.00	0.00	0.00	20.52
780	2023126011823	04/03/23 - 04/03/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126012092	04/06/23 - 04/06/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126012106	04/13/23 - 04/13/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126012240	04/24/23 - 04/24/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126012247	04/18/23 - 04/18/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126012322	04/26/23 - 04/26/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015471	04/07/23 - 04/07/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015714	04/07/23 - 04/07/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015760	04/27/23 - 04/27/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015763	04/14/23 - 04/14/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015766	04/03/23 - 04/03/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015787	04/21/23 - 04/21/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015827	04/03/23 - 04/03/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126015865	04/27/23 - 04/27/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023126016106	04/07/23 - 04/07/23	05/15/23	122.00	0.00	0.00	0.00	20.52
780	2023133025599	05/08/23 - 05/08/23	05/22/23	122.00	0.00	0.00	0.00	20.52
780	2023133026081	05/08/23 - 05/08/23	05/22/23	122.00	0.00	0.00	0.00	20.52
780	2023141002526	05/16/23 - 05/16/23	05/29/23	122.00	0.00	0.00	0.00	20.52
780	2023171036529	06/09/23 - 06/09/23	06/26/23	122.00	0.00	0.00	0.00	20.52
780	2023171042945	06/05/23 - 06/05/23	06/26/23	122.00	0.00	0.00	0.00	20.52
780	2023180035877	03/29/23 - 03/29/23	07/03/23	122.00	0.00	0.00	0.00	20.52
780	2023183003337	05/04/23 - 05/04/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003344	05/08/23 - 05/08/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003346	05/01/23 - 05/01/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003347	05/10/23 - 05/10/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003348	05/04/23 - 05/04/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003353	05/08/23 - 05/08/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003354	05/01/23 - 05/01/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003356	05/08/23 - 05/08/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023183003360	05/04/23 - 05/04/23	07/10/23	122.00	0.00	0.00	0.00	20.52
780	2023200069218	07/03/23 - 07/03/23	07/24/23	122.00	0.00	0.00	0.00	20.52

GRADY MEMORIAL HOSPITAL
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780	2023200069699	07/07/23 - 07/07/23	07/24/23	122.00	0.00	0.00	0.00	20.52
614	2023207038063	07/17/23 - 07/17/23	07/31/23	4,901.00	0.00	0.00	0.00	795.62
780	2023211003426	07/25/23 - 07/25/23	08/07/23	122.00	0.00	0.00	0.00	20.52
780	2023218002832	08/01/23 - 08/01/23	08/14/23	122.00	0.00	0.00	0.00	20.52
780	2023221053543	03/15/23 - 03/15/23	08/14/23	122.00	0.00	0.00	0.00	20.52
780	2023221056375	03/09/23 - 03/09/23	08/14/23	122.00	0.00	0.00	0.00	20.52
780	2023221063868	01/11/23 - 01/11/23	08/14/23	122.00	0.00	0.00	0.00	20.52
780	2023230031483	07/11/23 - 07/11/23	08/21/23	122.00	0.00	0.00	0.00	20.52
780	2023264037516	08/28/23 - 08/28/23	09/25/23	122.00	0.00	0.00	0.00	20.52
780	2023266022077	09/18/23 - 09/18/23	10/02/23	122.00	0.00	0.00	0.00	20.52
780	2023267002196	04/14/23 - 04/14/23	10/02/23	122.00	0.00	0.00	0.00	20.52
614	2023278040036	09/26/23 - 09/26/23	10/09/23	4,901.00	0.00	0.00	0.00	842.77
614	2023286032637	09/28/23 - 09/28/23	10/16/23	4,901.00	0.00	0.00	0.00	842.77
614	2023292027306	03/23/23 - 03/23/23	10/23/23	4,901.00	0.00	0.00	0.00	842.77
614	2023334016615	11/21/23 - 11/21/23	12/04/23	4,901.00	0.00	0.00	0.00	842.77
614	2023334016694	04/10/23 - 04/10/23	12/04/23	4,901.00	0.00	0.00	0.00	842.77
780	2023346052695	05/20/23 - 05/20/23	12/18/23	122.00	0.00	0.00	3,415.79	10.09
780	2024044068197	12/05/23 - 12/05/23	02/19/24	122.00	0.00	0.00	0.00	20.52
780	2324094000163	10/02/23 - 10/02/23	04/22/24	122.00	0.00	0.00	0.00	20.52
TOTAL				41,728.00	0.00	0.00	3,415.79	7,071.56

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,578,860.19	ADJUSTMENTS	0.00
COVERED CHARGES	1,701,432.90	CONTRACTUAL ALLOW	1,468,482.04
NON-COVERD CHARGES	877,427.29	TOTAL MEDICAID LIAB	232,950.86
		LESS: COB	232,950.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 869

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,794.55	0.00
MED/SURG SUPPLY	14,283.86	1,515.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,347.00	0.00
CT SCAN	46,031.00	46,176.00
PHYSICAL THERAPY	8,492.00	1,817.00
EKG/ECG	23,673.00	607.00
IV THERAPY	132,193.00	12,730.00
OPERATING ROOM	106,477.00	210,540.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,406.00	2,006.00
ANESTHESIA	55,471.00	0.00
GI SERVICES	3,327.00	33,891.00
EMERGENCY ROOM	307,286.00	40,273.00
RECOVERY ROOM	27,234.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	15,436.00	0.00
OCCUPATIONAL THERAPY	1,032.00	8,289.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	9,801.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	185,933.75	23,515.82
PSYCHIATRIC SERVICES	10,166.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,059.00	21,784.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	42,083.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	95,404.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,169.00	7,594.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,016.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	63,243.00	14,850.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	33,323.00	5,421.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,536.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	461,524.00	39,384.00
MRI SERVICES	21,651.00	19,692.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	568.62
INJECTABLE DRUGS	34,116.24	280,032.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,543.50	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	122.00	0.00

TOTAL ANCILLARY	1,701,432.90	877,427.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,701,432.90	877,427.29

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023342072648	11/22/23 - 11/22/23	12/11/23	122.00	0.00	0.00	20.52	0.00
TOTAL				122.00	0.00	0.00	20.52	0.00

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,394,851.98	ADJUSTMENTS	671.30
COVERED CHARGES	1,361,764.65	CONTRACTUAL ALLOW	1,316,384.77
NON-COVERD CHARGES	33,087.33	TOTAL MEDICAID LIAB	45,379.88
		LESS: COB	107.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	45,272.00

TOTAL NUMBER OF CLAIMS 676

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,352.61	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,509.00	0.00
CT SCAN	108,773.00	3,998.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	48,560.00	0.00
IV THERAPY	27,421.00	5,762.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	775,015.00	564.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,401.00	1,013.00
PSYCHIATRIC SERVICES	189.00	86.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,971.00	2,316.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,900.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,663.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	291,694.00	8,300.50
MRI SERVICES	0.00	9,582.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,316.04	1,465.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,361,764.65	33,087.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,361,764.65	33,087.33

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	117,204.97	ADJUSTMENTS	0.00
COVERED CHARGES	105,801.54	CONTRACTUAL ALLOW	104,257.55
NON-COVERD CHARGES	11,403.43	TOTAL MEDICAID LIAB	1,543.99
		LESS: COB	1,543.99
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,391.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,201.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,656.00	817.00
EKG/ECG	3,642.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,452.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,925.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	611.65	385.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	105,801.54	11,403.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,801.54	11,403.43

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,692,252.64	ADJUSTMENTS	412,714.50
COVERED CHARGES	35,907,490.01	CONTRACTUAL ALLOW	31,324,953.95
NON-COVERD CHARGES	2,784,762.63	TOTAL MEDICAID LIAB	4,582,536.06
		LESS: COB	23,304.59
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,559,231.47

TOTAL NUMBER OF CLAIMS 570

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,213.38	920.19
MED/SURG SUPPLY	433,509.62	27,094.28
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	254,063.00	25,591.00
CT SCAN	2,310,881.00	183,519.00
PHYSICAL THERAPY	5,994.00	16,114.00
EKG/ECG	27,315.00	4,856.00
IV THERAPY	227,511.00	99,315.00
OPERATING ROOM	14,449,631.69	1,706,510.31
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	52,088.00	0.00
ANESTHESIA	2,648,715.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,630,932.00	5,255.00
RECOVERY ROOM	2,073,172.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	435,285.00	0.00
OCCUPATIONAL THERAPY	0.00	6,012.00
SPEECH PATHOLOGY	0.00	3,864.00
RENAL DIALYSIS	0.00	3,300.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,284.00	2,436.00
PSYCHIATRIC SERVICES	30,807.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	36,554.00	12,203.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,098.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	17,281.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,500.00	91,324.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	1,707.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,678,161.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	146,169.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	880.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	667,727.53	22,697.00
MRI SERVICES	50,436.00	4,773.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	943.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	284.90
INJECTABLE DRUGS	6,988,814.87	470,425.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	581,684.92	78,400.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,907,490.01	2,784,762.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,907,490.01	2,784,762.63

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

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DR SE
ATLANTA,GA 30303-3031

PROVIDER NUMBER
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	53,783,776.86	ADJUSTMENTS	566,143.74
COVERED CHARGES	53,768,540.25	CONTRACTUAL ALLOW	47,958,105.82
NON-COVERD CHARGES	15,236.61	TOTAL MEDICAID LIAB	5,810,434.43
		LESS: COB	56,435.15
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,016.00
		REIMBURSEMENT	5,756,015.28

TOTAL NUMBER OF ADMISSIONS 556

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,732	0	4,172,388.00	0.00
ROUTINE NURSERY	57	0	105,456.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,789	0	4,277,844.00	0.00
SPECIAL CARE SERVICES				
CCU	974	0	6,888,128.00	0.00
ICU	641	0	5,145,104.00	0.00
NICU	12	0	135,864.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,627	0	12,169,096.00	0.00
TOTAL ACCOMODATIONS	3,416	0	16,446,940.00	0.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,426,480.83	0.00
MED/SURG SUPPLY	1,258,099.05	129.91
LABORATORY-GENERAL	6,991,638.45	1,170.00
RADIOLOGY-DIAGNOSTIC	815,421.00	0.00
CT SCAN	2,945,619.00	6,003.00
PHYSICAL THERAPY	202,946.00	0.00
EKG/ECG	413,168.00	0.00
IV THERAPY	609,532.00	0.00
OPERATING ROOM	2,493,085.00	0.00
LABOR/DELIVERY ROOM	208,785.00	0.00
RESPIRATORY SERVICES	6,122,287.00	0.00
ANESTHESIA	942,456.00	0.00
GI SERVICES	563,929.00	0.00
EMERGENCY ROOM	2,242,991.00	3,089.00
RECOVERY ROOM	147,405.00	0.00
LABORATORY PATHOLOGIC	264,510.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	116,178.00	0.00
SPEECH PATHOLOGY	113,826.00	0.00
RENAL DIALYSIS	0.00	3,294.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,601.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	181,480.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	719,922.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	148,056.20	1,550.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	938,392.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	71,237.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,453,314.39	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	304,082.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,620.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	462,116.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	153,423.33	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,321,600.25	15,236.61
TOTAL ACCOMODATIONS	16,446,940.00	0.00
TOTAL CHARGES	53,768,540.25	15,236.61

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	207,941.67	ADJUSTMENTS	0.00
COVERED CHARGES	207,941.67	CONTRACTUAL ALLOW	180,974.39
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	26,967.28
		LESS: COB	27,030.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	32	0	77,088.00	0.00
ROUTINE NURSERY	3	0	4,068.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	35	0	81,156.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	14,144.00	0.00
NICU	1	0	11,322.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	25,466.00	0.00
TOTAL ACCOMODATIONS	38	0	106,622.00	0.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,423.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,719.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,260.00	0.00	EDUCATION & TRAINING	660.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,829.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,405.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	6,136.00	0.00
IV THERAPY	1,297.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,930.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,248.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,771.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,089.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	798.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,128.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	322.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	830.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,664.24	0.00			

TOTAL ANCILLARY	101,319.67	0.00
TOTAL ACCOMODATIONS	106,622.00	0.00
TOTAL CHARGES	207,941.67	0.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,569,431.44	ADJUSTMENTS	119,205.29
COVERED CHARGES	21,362,621.22	CONTRACTUAL ALLOW	19,230,647.49
NON-COVERD CHARGES	1,206,810.22	TOTAL MEDICAID LIAB	2,131,973.73
		LESS: COB	7,904.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,124,069.46
		ALL OTHER	1,921,268.54
		FEE SCHEDULE-LAB	176,134.65
		INJECTABLE DRUGS	26,666.27

TOTAL NUMBER OF CLAIMS 3,519

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282,009.90	0.00
MED/SURG SUPPLY	269,188.07	43.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	764,097.00	4,204.00
CT SCAN	3,935,732.00	98,655.00
PHYSICAL THERAPY	204,437.00	10,651.00
EKG/ECG	431,200.00	3,136.00
IV THERAPY	1,157,608.00	38,138.00
OPERATING ROOM	914,872.00	150,521.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	207,805.00	4,892.00
ANESTHESIA	536,899.00	0.00
GI SERVICES	436,070.67	95,953.33
EMERGENCY ROOM	5,470,138.00	0.00
RECOVERY ROOM	124,855.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,977.00	2,766.00
SPEECH PATHOLOGY	28,208.00	7,232.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	644.00	3,059.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	436,410.20	21,032.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	376,686.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	52,901.30	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	319,476.00	29,862.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	447,464.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	869,974.60	263,019.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	292,939.00	2,704.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,220,249.00	88,885.00
MRI SERVICES	231,848.00	22,610.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	260,288.07	353,651.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	5,796.00
IMPL DEV CHARGE PATIENTS	87,644.41	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,362,621.22	1,206,810.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,362,621.22	1,206,810.22

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	210,531.98	ADJUSTMENTS	0.00
COVERED CHARGES	172,272.28	CONTRACTUAL ALLOW	155,203.50
NON-COVERD CHARGES	38,259.70	TOTAL MEDICAID LIAB	17,068.78
		LESS: COB	17,068.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,913.10	264.00
MED/SURG SUPPLY	6,145.36	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,296.00	0.00
CT SCAN	20,703.00	18,995.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	784.00	0.00
IV THERAPY	6,935.00	0.00
OPERATING ROOM	33,180.00	3,769.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,556.00	0.00
ANESTHESIA	15,567.00	0.00
GI SERVICES	11,144.00	0.00
EMERGENCY ROOM	27,517.00	0.00
RECOVERY ROOM	5,129.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,329.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,101.00	825.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,624.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,898.00	0.00
MRI SERVICES	0.00	12,272.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,275.80	2,134.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,175.02	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	172,272.28	38,259.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	172,272.28	38,259.70

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	413,385.20	ADJUSTMENTS	134.26
COVERED CHARGES	403,373.60	CONTRACTUAL ALLOW	392,565.67
NON-COVERD CHARGES	10,011.60	TOTAL MEDICAID LIAB	10,807.93
		LESS: COB	100.06
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,707.87

TOTAL NUMBER OF CLAIMS 161

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,245.40	0.00
MED/SURG SUPPLY	452.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,402.00	0.00
CT SCAN	20,182.00	7,389.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,192.00	0.00
IV THERAPY	18,214.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	243,425.00	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 SERVICE	3,591.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,855.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,624.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	65,546.00	1,057.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,645.20	1,565.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	403,373.60	10,011.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	403,373.60	10,011.60

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,945.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,945.00	CONTRACTUAL ALLOW	2,877.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	67.13
		LESS: COB	67.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,344.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,601.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,945.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,945.00	0.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,212,023.31	ADJUSTMENTS	10,579.50
COVERED CHARGES	1,120,183.31	CONTRACTUAL ALLOW	1,051,416.56
NON-COVERD CHARGES	91,840.00	TOTAL MEDICAID LIAB	68,766.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	68,766.75

TOTAL NUMBER OF CLAIMS 13

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,610.00	0.00
MED/SURG SUPPLY	31,117.20	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,772.00	0.00
CT SCAN	30,023.00	0.00
PHYSICAL THERAPY	0.00	551.00
EKG/ECG	0.00	0.00
IV THERAPY	133.00	1,752.00
OPERATING ROOM	159,384.00	17,390.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,261.00	122.00
ANESTHESIA	43,470.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,450.00	0.00
RECOVERY ROOM	13,151.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,718.00	3,436.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	679,705.87	66,020.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,186.00	616.00
MRI SERVICES	13,586.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,903.10	1,953.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	106,713.14	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,120,183.31	91,840.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,120,183.31	91,840.00

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	240,032,036.84	ADJUSTMENTS	12,795,419.25
COVERED CHARGES	239,593,872.83	CONTRACTUAL ALLOW	214,284,958.78
NON-COVERD CHARGES	438,164.01	TOTAL MEDICAID LIAB	25,308,914.05
		LESS: COB	297,641.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	32,256.00
		REIMBURSEMENT	25,043,528.58

TOTAL NUMBER OF ADMISSIONS 2,269

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,982	0	16,956,693.00	0.00
ROUTINE NURSERY	1,874	0	9,489,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,856	0	26,446,193.00	0.00
SPECIAL CARE SERVICES				
CCU	2,554	0	18,256,368.00	0.00
ICU	3,026	0	23,191,801.00	0.00
NICU	538	0	6,099,160.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	77	0	826,210.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,195	0	48,373,539.00	0.00
TOTAL ACCOMODATIONS	15,051	0	74,819,732.00	0.00

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,073,063.37	0.00
MED/SURG SUPPLY	7,578,064.73	124,131.31
LABORATORY-GENERAL	25,435,769.70	0.00
RADIOLOGY-DIAGNOSTIC	3,271,795.00	0.00
CT SCAN	10,974,811.00	60,357.00
PHYSICAL THERAPY	901,056.00	0.00
EKG/ECG	1,628,174.00	0.00
IV THERAPY	1,887,548.00	0.00
OPERATING ROOM	24,084,171.72	0.00
LABOR/DELIVERY ROOM	4,687,080.00	0.00
RESPIRATORY SERVICES	16,071,647.00	0.00
ANESTHESIA	6,111,533.33	0.00
GI SERVICES	1,539,130.00	0.00
EMERGENCY ROOM	5,082,297.00	0.00
RECOVERY ROOM	1,745,002.00	0.00
LABORATORY PATHOLOGIC	1,117,384.00	0.00
RADIOLOGY THERAPEUTIC	650,737.00	0.00
OCCUPATIONAL THERAPY	435,011.00	0.00
SPEECH PATHOLOGY	563,271.00	0.00
RENAL DIALYSIS	0.00	197,640.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	86,618.00	0.00
PSYCHIATRIC SERVICES	11,478.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	605,743.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,977,624.00	46,085.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	428,203.20	4,362.30
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,364,606.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	791,072.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,678,505.87	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,417,876.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	103,158.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,266,657.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,588.40
INJECTABLE DRUGS	8,136.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	7,196,917.31	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	164,774,140.83	438,164.01
TOTAL ACCOMODATIONS	74,819,732.00	0.00
TOTAL CHARGES	239,593,872.83	438,164.01

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,709,292.21	ADJUSTMENTS	0.00
COVERED CHARGES	4,708,985.01	CONTRACTUAL ALLOW	4,219,706.41
NON-COVERD CHARGES	307.20	TOTAL MEDICAID LIAB	489,278.60
		LESS: COB	491,357.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,079.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 72

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	100	0	240,900.00	0.00
ROUTINE NURSERY	96	0	319,740.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	196	0	560,640.00	0.00
SPECIAL CARE SERVICES				
CCU	49	0	346,528.00	0.00
ICU	16	0	124,260.00	0.00
NICU	77	0	871,794.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	1	0	10,730.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	143	0	1,353,312.00	0.00
TOTAL ACCOMODATIONS	339	0	1,913,952.00	0.00

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	564,288.40	0.00
MED/SURG SUPPLY	123,518.08	0.00
LABORATORY-GENERAL	341,724.90	0.00
RADIOLOGY-DIAGNOSTIC	35,050.00	0.00
CT SCAN	76,733.00	0.00
PHYSICAL THERAPY	6,709.00	0.00
EKG/ECG	8,624.00	0.00
IV THERAPY	27,689.00	0.00
OPERATING ROOM	257,112.00	0.00
LABOR/DELIVERY ROOM	393,934.00	0.00
RESPIRATORY SERVICES	394,561.00	0.00
ANESTHESIA	80,470.00	0.00
GI SERVICES	11,144.00	0.00
EMERGENCY ROOM	34,059.00	0.00
RECOVERY ROOM	48,982.00	0.00
LABORATORY PATHOLOGIC	13,265.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,996.00	0.00
SPEECH PATHOLOGY	5,541.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,830.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,714.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,956.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,668.00	307.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,987.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,830.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	56,784.36	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	80,879.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,754.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	18,149.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	117,081.27	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,795,033.01	307.20
TOTAL ACCOMODATIONS	1,913,952.00	0.00
TOTAL CHARGES	4,708,985.01	307.20

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,989,463.41	ADJUSTMENTS	525,336.53
COVERED CHARGES	37,181,886.49	CONTRACTUAL ALLOW	32,735,249.29
NON-COVERD CHARGES	3,807,576.92	TOTAL MEDICAID LIAB	4,446,637.20
		LESS: COB	57,332.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,389,304.63
		ALL OTHER	3,978,909.43
		FEE SCHEDULE-LAB	389,511.93
		INJECTABLE DRUGS	20,883.27

TOTAL NUMBER OF CLAIMS 8,575

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	636,243.33	1,324.80
MED/SURG SUPPLY	687,172.39	0.00
LABORATORY-GENERAL	0.00	314.30
RADIOLOGY-DIAGNOSTIC	1,553,298.00	17,404.00
CT SCAN	5,833,953.00	427,190.00
PHYSICAL THERAPY	360,479.00	31,136.00
EKG/ECG	614,691.00	19,600.00
IV THERAPY	1,433,031.00	60,794.00
OPERATING ROOM	2,887,614.69	1,503,504.31
LABOR/DELIVERY ROOM	6,674.00	0.00
RESPIRATORY SERVICES	242,763.00	7,447.00
ANESTHESIA	1,846,432.00	0.00
GI SERVICES	496,001.00	160,381.00
EMERGENCY ROOM	6,665,706.00	25,664.00
RECOVERY ROOM	494,967.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,351,814.00	240,455.00
OCCUPATIONAL THERAPY	50,878.00	31,050.00
SPEECH PATHOLOGY	20,067.00	26,947.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,158.00	4,840.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,506,835.73	92,297.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	86,825.46	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	380,020.10	47,661.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	937,296.00	134,673.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	328,390.00	31,531.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,287,748.09	420,677.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	577,500.00	20,373.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	649.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,768,356.38	136,849.30
MRI SERVICES	1,681,601.00	143,806.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	226,266.03	218,600.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	209,289.29	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,816.00	0.00

TOTAL ANCILLARY	37,181,886.49	3,805,167.92
TOTAL ACCOMODATIONS	0.00	2,409.00
TOTAL CHARGES	37,181,886.49	3,807,576.92

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022193056230	07/07/22 - 07/07/22	07/18/22	159.00	0.00	0.00	0.00	20.52
780	2022196069361	07/11/22 - 07/11/22	07/25/22	159.00	0.00	0.00	0.00	20.52
780	2022279000100	09/12/22 - 09/12/22	10/10/22	159.00	0.00	0.00	0.00	20.52
780	2022280105063	10/03/22 - 10/03/22	10/17/22	159.00	0.00	0.00	0.00	20.52
780	2022315082834	11/07/22 - 11/07/22	11/21/22	159.00	0.00	0.00	0.00	20.52
780	2022347007503	12/06/22 - 12/06/22	12/19/22	159.00	0.00	0.00	0.00	20.52
780	2022355023133	12/15/22 - 12/15/22	12/26/22	159.00	0.00	0.00	0.00	20.52
780	2023011090446	01/06/23 - 01/06/23	01/16/23	159.00	0.00	0.00	0.00	20.52
780	2023023044567	01/18/23 - 01/18/23	01/30/23	159.00	0.00	0.00	0.00	20.52
780	2023041143898	02/06/23 - 02/06/23	02/20/23	159.00	0.00	0.00	0.00	20.52
780	2023044046109	02/08/23 - 02/08/23	02/20/23	159.00	0.00	0.00	0.00	20.52
780	2023048087337	02/13/23 - 02/13/23	02/27/23	159.00	0.00	0.00	0.00	20.52
780	2023051039084	02/14/23 - 02/14/23	02/27/23	159.00	0.00	0.00	0.00	20.52
780	2023055098910	02/20/23 - 02/20/23	03/06/23	159.00	0.00	0.00	0.00	20.52
780	2023058044257	02/22/23 - 02/22/23	03/06/23	318.00	0.00	0.00	0.00	20.52
780	2023076112823	03/13/23 - 03/13/23	03/27/23	159.00	0.00	0.00	0.00	20.52
780	2023076112833	03/13/23 - 03/13/23	03/27/23	159.00	0.00	0.00	0.00	20.52
780	2023095014856	03/14/23 - 03/14/23	04/10/23	159.00	0.00	0.00	0.00	20.52
780	2023112026217	04/17/23 - 04/17/23	05/01/23	159.00	0.00	0.00	0.00	20.52
780	2023125098163	05/01/23 - 05/01/23	05/15/23	159.00	0.00	0.00	0.00	20.52
780	2023173132883	05/10/23 - 05/10/23	06/26/23	159.00	0.00	0.00	0.00	20.52
780	2023242077210	03/01/23 - 03/01/23	09/04/23	159.00	0.00	0.00	0.00	20.52
780	5923267000103	01/04/23 - 01/04/23	10/02/23	159.00	0.00	0.00	0.00	20.52
TOTAL				3,816.00	0.00	0.00	0.00	471.96

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,495,970.09	ADJUSTMENTS	0.00
COVERED CHARGES	1,099,680.60	CONTRACTUAL ALLOW	969,085.95
NON-COVERD CHARGES	396,289.49	TOTAL MEDICAID LIAB	130,594.65
		LESS: COB	130,594.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 136

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,951.76	0.00
MED/SURG SUPPLY	24,788.54	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,793.00	0.00
CT SCAN	56,646.00	42,088.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	14,267.00	784.00
IV THERAPY	36,767.00	0.00
OPERATING ROOM	249,833.48	289,439.52
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,404.00	0.00
ANESTHESIA	273,373.00	0.00
GI SERVICES	22,288.00	4,648.00
EMERGENCY ROOM	99,805.00	0.00
RECOVERY ROOM	76,318.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,586.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	7,911.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,142.00	23,730.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,105.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,769.74	5,200.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	16,286.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,947.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90,982.18	3,228.17
MRI SERVICES	3,972.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,800.01	17,313.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	23,802.89	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,099,680.60	396,289.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,099,680.60	396,289.49

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	515,397.70	ADJUSTMENTS	469.91
COVERED CHARGES	471,302.30	CONTRACTUAL ALLOW	460,762.89
NON-COVERD CHARGES	44,095.40	TOTAL MEDICAID LIAB	10,539.41
		LESS: COB	66.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,472.61

TOTAL NUMBER OF CLAIMS 157

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,851.50	0.00
MED/SURG SUPPLY	771.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,956.00	0.00
CT SCAN	30,094.00	18,876.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,920.00	0.00
IV THERAPY	24,134.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,453.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	288,136.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,662.00	5,837.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,160.00	3,120.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,827.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	64,830.00	216.00
MRI SERVICES	6,109.00	15,424.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,398.80	622.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	471,302.30	44,095.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	471,302.30	44,095.40

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,939.50	ADJUSTMENTS	0.00
COVERED CHARGES	38,292.30	CONTRACTUAL ALLOW	37,688.13
NON-COVERD CHARGES	647.20	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	610.60	0.00	OTHER LAB	1,624.00	0.00
MED/SURG SUPPLY	55.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	742.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,371.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,288.00	391.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,701.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,771.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.70	256.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	38,292.30	647.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,292.30	647.20

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,888,449.05	ADJUSTMENTS	35,442.96
COVERED CHARGES	7,802,868.51	CONTRACTUAL ALLOW	7,297,387.85
NON-COVERD CHARGES	1,085,580.54	TOTAL MEDICAID LIAB	505,480.66
		LESS: COB	12,281.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	493,198.83

TOTAL NUMBER OF CLAIMS 85

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,848.20	0.00
MED/SURG SUPPLY	673,430.30	70,287.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,040.00	4,444.00
CT SCAN	36,441.00	0.00
PHYSICAL THERAPY	700.00	9,891.00
EKG/ECG	7,056.00	1,568.00
IV THERAPY	6,561.00	0.00
OPERATING ROOM	1,550,354.96	780,420.04
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,662.00	0.00
ANESTHESIA	833,532.00	0.00
GI SERVICES	48,499.00	0.00
EMERGENCY ROOM	18,014.00	0.00
RECOVERY ROOM	225,574.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,998,813.00	27,622.00
OCCUPATIONAL THERAPY	0.00	3,787.00
SPEECH PATHOLOGY	0.00	3,284.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,669.00	8,590.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,712.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	263.30
AUDIOLOGY	0.00	0.00
CARDIOLOGY	48,327.00	65,092.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	136,348.69	12,195.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,661.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	82,435.00	428.00
MRI SERVICES	6,136.00	9,511.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,102.04	88,197.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,947,952.32	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,802,868.51	1,085,580.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,802,868.51	1,085,580.54

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,048,841.06	ADJUSTMENTS	0.00
COVERED CHARGES	952,696.07	CONTRACTUAL ALLOW	899,402.45
NON-COVERD CHARGES	96,144.99	TOTAL MEDICAID LIAB	53,293.62
		LESS: COB	53,293.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

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

KENNESTONE HOSPITAL, INC
677 CHURCH STREET, NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,825.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,757.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,185.00	274.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	174,389.41	92,585.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,753.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,724.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,111.30	3,285.40
RADIOLOGY THERAPEUTIC	95,487.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	519,462.78	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	952,696.07	96,144.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	952,696.07	96,144.99

** END OF REPORT **

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,145,245.04	ADJUSTMENTS	388,886.98
COVERED CHARGES	47,070,607.58	CONTRACTUAL ALLOW	42,111,964.13
NON-COVERD CHARGES	1,074,637.46	TOTAL MEDICAID LIAB	4,958,643.45
		LESS: COB	40,301.24
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	945.00
		REIMBURSEMENT	4,919,287.21

TOTAL NUMBER OF ADMISSIONS 564

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,108	0	2,711,918.00	0.00
ROUTINE NURSERY	28	0	27,710.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,136	0	2,739,628.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	478	0	1,606,982.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	478	0	1,606,982.00	0.00
TOTAL ACCOMODATIONS	2,614	0	4,346,610.00	0.00

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,204,140.29	1,622.07
MED/SURG SUPPLY	3,116,421.40	41,010.30
LABORATORY-GENERAL	10,405,915.75	78,279.25
RADIOLOGY-DIAGNOSTIC	967,183.00	5,644.25
CT SCAN	2,735,447.10	687,082.00
PHYSICAL THERAPY	1,005,985.25	0.00
EKG/ECG	546,932.00	2,661.00
IV THERAPY	49,911.00	2,376.00
OPERATING ROOM	1,814,606.00	0.00
LABOR/DELIVERY ROOM	283,414.00	0.00
RESPIRATORY SERVICES	1,796,168.00	0.00
ANESTHESIA	381,345.00	0.00
GI SERVICES	70,855.00	7,581.00
EMERGENCY ROOM	1,723,468.00	12,753.00
RECOVERY ROOM	265,740.00	0.00
LABORATORY PATHOLOGIC	66,185.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	829,449.75	0.00
SPEECH PATHOLOGY	201,510.00	0.00
RENAL DIALYSIS	348,963.00	23,764.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,296.00	850.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	230,070.00	23,151.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	83,914.00	127,196.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	293,073.00	48,484.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,893,330.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	66,102.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	47,428.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	169,965.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,178.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	798,726.00	0.09
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,143,975.24	10,005.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	178,478.80	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	42,723,997.58	1,074,637.46
TOTAL ACCOMODATIONS	4,346,610.00	0.00
TOTAL CHARGES	47,070,607.58	1,074,637.46

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	164,237.50	ADJUSTMENTS	0.00
COVERED CHARGES	164,237.50	CONTRACTUAL ALLOW	143,899.69
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	20,337.81
		LESS: COB	20,337.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11	0	15,046.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	15,046.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	15,046.00	0.00

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,088.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,957.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,925.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,413.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,257.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	976.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,831.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,311.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,918.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,788.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,526.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200.00	0.00			

TOTAL ANCILLARY	149,191.50	0.00
TOTAL ACCOMODATIONS	15,046.00	0.00
TOTAL CHARGES	164,237.50	0.00

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,455,811.12	ADJUSTMENTS	182,996.11
COVERED CHARGES	29,009,581.46	CONTRACTUAL ALLOW	27,172,043.34
NON-COVERD CHARGES	3,446,229.66	TOTAL MEDICAID LIAB	1,837,538.12
		LESS: COB	3,959.73
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,833,578.39
		ALL OTHER	1,643,894.95
		FEE SCHEDULE-LAB	174,577.60
		INJECTABLE DRUGS	15,105.84

TOTAL NUMBER OF CLAIMS 4,141

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,896.64	179,371.75
MED/SURG SUPPLY	1,325,358.30	59,448.55
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,634,648.00	37,143.00
CT SCAN	5,421,338.00	288,716.00
PHYSICAL THERAPY	421,253.00	69,187.75
EKG/ECG	674,065.00	84,191.00
IV THERAPY	556,939.00	0.00
OPERATING ROOM	2,235,781.00	1,455,681.00
LABOR/DELIVERY ROOM	36,685.00	0.00
RESPIRATORY SERVICES	55,767.50	22,449.25
ANESTHESIA	942,498.00	0.00
GI SERVICES	256,194.67	161,453.33
EMERGENCY ROOM	4,036,006.00	0.00
RECOVERY ROOM	356,411.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	107,871.50	21,092.75
SPEECH PATHOLOGY	5,472.00	10,673.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	102,922.00	10,451.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	44,992.00	0.00
OTHER IMAGING SERVICE	584,523.75	194,596.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,662.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	407,186.00	92,080.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	466,008.00	122,454.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	287,062.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	175,912.76	8,430.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	330,494.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,829.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,770,231.05	257,908.25
MRI SERVICES	731,945.00	17,417.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	642,878.74	253,506.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	27,210.00
IMPL DEV CHARGE PATIENTS	98,578.80	69,940.40
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	29,009,581.46	3,446,229.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,009,581.46	3,446,229.66

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	779,997.95	ADJUSTMENTS	0.00
COVERED CHARGES	522,400.20	CONTRACTUAL ALLOW	489,249.24
NON-COVERD CHARGES	257,597.75	TOTAL MEDICAID LIAB	33,150.96
		LESS: COB	33,150.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 63

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,427.75	7,319.50
MED/SURG SUPPLY	53,476.55	19,996.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,171.00	0.00
CT SCAN	16,424.00	65,396.00
PHYSICAL THERAPY	0.00	3,030.50
EKG/ECG	11,089.00	0.00
IV THERAPY	8,267.00	0.00
OPERATING ROOM	80,485.00	90,784.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	35,639.00	0.00
GI SERVICES	0.00	5,054.00
EMERGENCY ROOM	45,990.00	0.00
RECOVERY ROOM	19,078.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,576.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	595.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,937.00	5,962.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,777.00	12,060.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	45,399.00	17,495.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	25,158.00	1,456.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	96,714.50	3,941.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,895.00	20,069.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	17,877.40	3,456.40
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	522,400.20	257,597.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	522,400.20	257,597.75

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,380,698.50	ADJUSTMENTS	156.64
COVERED CHARGES	1,247,246.50	CONTRACTUAL ALLOW	1,225,238.58
NON-COVERD CHARGES	133,452.00	TOTAL MEDICAID LIAB	22,007.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	22,007.92

TOTAL NUMBER OF CLAIMS 281

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,646.25	3,843.00
MED/SURG SUPPLY	10,172.25	1,138.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	117,874.50	0.00
CT SCAN	282,500.00	99,980.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	20,760.00	976.00
IV THERAPY	34,896.00	0.00
OPERATING ROOM	769.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,179.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	426,051.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,983.00	9,235.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	720.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	304,719.50	7,275.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,526.00	11,003.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,247,246.50	133,452.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,247,246.50	133,452.00

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,877.75	ADJUSTMENTS	0.00
COVERED CHARGES	18,980.75	CONTRACTUAL ALLOW	18,745.79
NON-COVERD CHARGES	4,897.00	TOTAL MEDICAID LIAB	234.96
		LESS: COB	234.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	754.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	887.00	0.00
IV THERAPY	1,568.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,606.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,613.25	3,851.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,552.25	1,045.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,980.75	4,897.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,980.75	4,897.00

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	585,689.40	ADJUSTMENTS	0.00
COVERED CHARGES	570,746.85	CONTRACTUAL ALLOW	538,398.03
NON-COVERD CHARGES	14,942.55	TOTAL MEDICAID LIAB	32,348.82
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	32,348.82

TOTAL NUMBER OF CLAIMS 6

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,782.25	3,954.00
MED/SURG SUPPLY	128,331.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,530.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	3,689.00
EKG/ECG	976.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	215,729.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	50,695.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,704.00	0.00
RECOVERY ROOM	14,630.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,690.75
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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,812.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,369.50	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,293.00	3,068.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	64,894.00	1,540.80
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	570,746.85	14,942.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	570,746.85	14,942.55

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,600.68	ADJUSTMENTS	0.00
COVERED CHARGES	88,600.68	CONTRACTUAL ALLOW	54,602.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	33,998.34
		LESS: COB	1,955.36
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	32,042.98

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	24	0	15,144.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	24	0	15,144.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	24	0	15,144.00	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,863.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,777.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,639.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	426.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,362.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	392.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,203.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,603.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,456.68	0.00
TOTAL ACCOMODATIONS	15,144.00	0.00
TOTAL CHARGES	88,600.68	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	921,156.87	ADJUSTMENTS	20,537.75
COVERED CHARGES	820,752.85	CONTRACTUAL ALLOW	602,997.01
NON-COVERD CHARGES	100,404.02	TOTAL MEDICAID LIAB	217,755.84
		LESS: COB	188.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	217,567.47
		ALL OTHER	171,931.48
		FEE SCHEDULE-LAB	44,572.45
		INJECTABLE DRUGS	1,063.54

TOTAL NUMBER OF CLAIMS 1,013

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,261.00	0.00
MED/SURG SUPPLY	5,069.85	71.77
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,927.00	684.00
CT SCAN	123,483.00	62,861.00
PHYSICAL THERAPY	43,026.00	3,542.00
EKG/ECG	14,896.00	0.00
IV THERAPY	42,510.00	3,094.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	760.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	195,828.00	1,179.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,749.00	0.00
OCCUPATIONAL THERAPY	4,936.00	896.00
SPEECH PATHOLOGY	1,806.00	2,296.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	130.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,052.00	1,250.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,176.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,734.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,285.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	284,596.00	6,268.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,528.00	18,262.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	820,752.85	100,404.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	820,752.85	100,404.02

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,341.53	ADJUSTMENTS	0.00
COVERED CHARGES	12,139.53	CONTRACTUAL ALLOW	8,774.64
NON-COVERD CHARGES	202.00	TOTAL MEDICAID LIAB	3,364.89
		LESS: COB	3,364.89
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	887.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,898.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,315.00	202.00
EKG/ECG	196.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,594.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,139.53	202.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,139.53	202.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,388.82	ADJUSTMENTS	70.00
COVERED CHARGES	55,967.80	CONTRACTUAL ALLOW	49,947.80
NON-COVERD CHARGES	3,421.02	TOTAL MEDICAID LIAB	6,020.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,020.00

TOTAL NUMBER OF CLAIMS 86

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,567.75	0.00
MED/SURG SUPPLY	215.80	71.77
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,968.00	643.00
CT SCAN	5,769.00	1,645.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	980.00	0.00
IV THERAPY	3,871.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,633.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,203.00	212.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,760.25	719.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	55,967.80	3,421.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,967.80	3,421.02

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	417.00	ADJUSTMENTS	0.00
COVERED CHARGES	417.00	CONTRACTUAL ALLOW	347.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	417.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	417.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	417.00	0.00

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
116 W THIGPEN AVENUE
LAKELAND,GA 31635-1006

PROVIDER NUMBER
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	299,395.17	ADJUSTMENTS	0.00
COVERED CHARGES	234,839.17	CONTRACTUAL ALLOW	42,764.53
NON-COVERD CHARGES	64,556.00	TOTAL MEDICAID LIAB	192,074.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	192,074.64

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	90	0	28,480.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	90	0	28,480.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	90	0	28,480.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE I
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610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,675.00	50.00
MED/SURG SUPPLY	18,997.60	0.00
LABORATORY-GENERAL	50,441.00	3,672.00
RADIOLOGY-DIAGNOSTIC	5,474.00	0.00
CT SCAN	4,591.00	57,955.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,800.00	175.00
IV THERAPY	22,425.00	969.00
OPERATING ROOM	10,886.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,077.00	0.00
ANESTHESIA	3,276.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,101.57	0.00
RECOVERY ROOM	1,293.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	401.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	815.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	314.00	1,416.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,290.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	200.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	815.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,487.00	319.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	206,359.17	64,556.00
TOTAL ACCOMODATIONS	28,480.00	0.00
TOTAL CHARGES	234,839.17	64,556.00

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,993,289.50	ADJUSTMENTS	1,617.48
COVERED CHARGES	1,755,488.33	CONTRACTUAL ALLOW	955,961.90
NON-COVERD CHARGES	237,801.17	TOTAL MEDICAID LIAB	799,526.43
		LESS: COB	4,200.54
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	795,325.89
		ALL OTHER	766,169.34
		FEE SCHEDULE-LAB	27,378.02
		INJECTABLE DRUGS	1,778.53

TOTAL NUMBER OF CLAIMS 1,221

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,173.00	3,195.00
MED/SURG SUPPLY	24,295.11	70.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,911.00	12,090.00
CT SCAN	199,789.00	114,275.00
PHYSICAL THERAPY	62,687.00	12,067.00
EKG/ECG	20,690.00	0.00
IV THERAPY	114,220.00	9,170.00
OPERATING ROOM	81,690.00	24,808.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,870.00	679.00
ANESTHESIA	25,740.00	4,914.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	602,139.22	1,564.00
RECOVERY ROOM	1,611.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,632.00	9,293.00
SPEECH PATHOLOGY	0.00	401.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,035.00	458.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	25,766.00	8,967.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,218.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	29,030.00	6,387.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	58,724.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,430.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	30,582.00	3,745.17

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	10,697.00	471.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	240,251.00	17,695.00
MRI SERVICES	44,907.00	1,910.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,401.00	5,642.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,755,488.33	237,801.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,755,488.33	237,801.17

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,388.62	ADJUSTMENTS	0.00
COVERED CHARGES	6,339.62	CONTRACTUAL ALLOW	3,905.52
NON-COVERD CHARGES	12,049.00	TOTAL MEDICAID LIAB	2,434.10
		LESS: COB	2,434.10
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,804.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	154.00	FEE SCHEDULE LAB	1,508.00	66.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,222.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,199.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	400.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,339.62	12,049.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,339.62	12,049.00

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	181,194.05	ADJUSTMENTS	0.00
COVERED CHARGES	156,324.05	CONTRACTUAL ALLOW	149,901.81
NON-COVERD CHARGES	24,870.00	TOTAL MEDICAID LIAB	6,422.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,422.24

TOTAL NUMBER OF CLAIMS 82

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	404.00	80.00
MED/SURG SUPPLY	34.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,115.00	0.00
CT SCAN	34,994.00	23,000.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,400.00	0.00
IV THERAPY	9,278.00	402.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	86,110.05	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	582.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	708.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	348.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	815.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,244.00	1,187.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,292.00	201.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	156,324.05	24,870.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	156,324.05	24,870.00

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	760.00	ADJUSTMENTS	0.00
COVERED CHARGES	760.00	CONTRACTUAL ALLOW	681.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	760.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	760.00	0.00

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	84,082.41	ADJUSTMENTS	0.00
COVERED CHARGES	64,361.41	CONTRACTUAL ALLOW	40,256.37
NON-COVERD CHARGES	19,721.00	TOTAL MEDICAID LIAB	24,105.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	24,105.04

TOTAL NUMBER OF CLAIMS 4

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	580.00	140.00
MED/SURG SUPPLY	19,656.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	936.00	0.00
CT SCAN	10,515.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	175.00	0.00
IV THERAPY	0.00	5.00
OPERATING ROOM	20,186.00	15,734.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	81.00	0.00
ANESTHESIA	1,404.00	3,276.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,599.81	0.00
RECOVERY ROOM	1,929.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,661.00	66.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	318.00	500.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,320.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	64,361.41	19,721.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,361.41	19,721.00

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	366,717.36	ADJUSTMENTS	15,277.92
COVERED CHARGES	349,957.38	CONTRACTUAL ALLOW	244,439.76
NON-COVERD CHARGES	16,759.98	TOTAL MEDICAID LIAB	105,517.62
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	105,517.62

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	93	0	125,017.50	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	93	0	125,017.50	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	93	0	125,017.50	0.00

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,262.85	311.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,179.77	59.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,210.88	10,600.42	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,555.94	975.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,031.56	1,772.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,551.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,366.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	69.37	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,989.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	954.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,928.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,582.50	2,870.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,540.00	0.00	INJECTABLE DRUGS	3,894.11	169.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,149.54	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,485.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,826.46	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,861.53	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,105.00	0.00			

TOTAL ANCILLARY	224,939.88	16,759.98
TOTAL ACCOMODATIONS	125,017.50	0.00
TOTAL CHARGES	349,957.38	16,759.98

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER 000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,435,803.54	ADJUSTMENTS	13,097.71
COVERED CHARGES	1,353,109.55	CONTRACTUAL ALLOW	1,181,579.30
NON-COVERD CHARGES	82,693.99	TOTAL MEDICAID LIAB	171,530.25
		LESS: COB	138.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	171,391.42
		ALL OTHER	135,916.48
		FEE SCHEDULE-LAB	29,859.57
		INJECTABLE DRUGS	5,615.37

TOTAL NUMBER OF CLAIMS 898

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,687.44	1,970.25
MED/SURG SUPPLY	13,291.56	5,434.14
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,382.04	0.00
CT SCAN	131,276.67	8,388.36
PHYSICAL THERAPY	5,799.20	3,966.25
EKG/ECG	9,259.02	0.00
IV THERAPY	25,111.07	251.70
OPERATING ROOM	14,974.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	39,220.15	0.00
GI SERVICES	166,117.34	29,404.34
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	19,056.26	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	2,083.51
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,341.96	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	75,258.69	2,558.55
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,047.39	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,359.49	4,027.22
AUDIOLOGY	0.00	0.00
CARDIOLOGY	63,909.34	2,937.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,263.44	10,911.10

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	79,444.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	271,037.05	6,566.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	313,272.94	4,195.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,353,109.55	82,693.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,353,109.55	82,693.99

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

A CAMPUS OF TIFT REGIONAL MEDIAL CENTER
260 MJ TAYLOR ROAD
ADEL,GA 31620-3485

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,930.16	ADJUSTMENTS	0.00
COVERED CHARGES	88,151.91	CONTRACTUAL ALLOW	28,816.78
NON-COVERD CHARGES	778.25	TOTAL MEDICAID LIAB	59,335.13
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	59,335.13

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	47	0	24,440.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	24,440.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	47	0	24,440.00	0.00

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,576.24	0.00
MED/SURG SUPPLY	6,303.67	0.00
LABORATORY-GENERAL	13,336.00	0.00
RADIOLOGY-DIAGNOSTIC	1,760.00	0.00
CT SCAN	7,070.00	0.00
PHYSICAL THERAPY	480.00	0.00
EKG/ECG	1,048.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,162.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,750.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	633.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	348.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,025.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	388.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	778.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,832.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	63,711.91	778.25
TOTAL ACCOMODATIONS	24,440.00	0.00
TOTAL CHARGES	88,151.91	778.25

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	397,557.85	ADJUSTMENTS	0.00
COVERED CHARGES	332,805.97	CONTRACTUAL ALLOW	207,133.57
NON-COVERD CHARGES	64,751.88	TOTAL MEDICAID LIAB	125,672.40
		LESS: COB	148.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	125,523.80
		ALL OTHER	117,161.87
		FEE SCHEDULE-LAB	8,145.80
		INJECTABLE DRUGS	216.13

TOTAL NUMBER OF CLAIMS 372

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,290.00	4,227.74
MED/SURG SUPPLY	2,560.34	359.96
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,617.00	4,878.00
CT SCAN	32,766.00	2,426.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,122.00	1,310.00
IV THERAPY	1,447.00	88.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	918.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	167,775.00	1,752.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	360.20	90.05
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,597.00	0.00
BLOOD	806.00	806.00
BLOOD STORAGE & PRO.	1,178.28	310.28
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	3,770.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	1,950.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,808.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	11,523.85
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	86,912.15	9,052.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,649.00	22,208.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	332,805.97	64,751.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	332,805.97	64,751.88

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	939.04	ADJUSTMENTS	0.00
COVERED CHARGES	939.04	CONTRACTUAL ALLOW	474.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	464.54
		LESS: COB	464.54
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	121.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	818.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	939.04	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	939.04	0.00

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,618.90	ADJUSTMENTS	0.00
COVERED CHARGES	37,467.40	CONTRACTUAL ALLOW	34,597.40
NON-COVERD CHARGES	3,151.50	TOTAL MEDICAID LIAB	2,870.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,870.00

TOTAL NUMBER OF CLAIMS 41

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.00	0.00
MED/SURG SUPPLY	47.40	110.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	760.00	302.00
CT SCAN	3,669.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	524.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,695.00	600.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	900.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,520.00	198.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	189.00	1,041.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,467.40	3,151.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,467.40	3,151.50

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	489,630.71	ADJUSTMENTS	42,073.74
COVERED CHARGES	473,007.71	CONTRACTUAL ALLOW	230,700.06
NON-COVERD CHARGES	16,623.00	TOTAL MEDICAID LIAB	242,307.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	242,307.65

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	117	0	138,619.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	117	0	138,619.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	117	0	138,619.00	0.00

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,160.42	0.00	OTHER LAB	2,501.00	0.00
MED/SURG SUPPLY	10,006.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	99,278.00	157.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,261.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,079.00	15,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,200.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,116.00	0.00	MRI SERVICES	16,414.00	0.00
IV THERAPY	16,054.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,101.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,142.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,476.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,540.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	714.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,705.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	512.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	402.00	0.00	NO CC/INVALID REV CODE	6,782.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,696.00	670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,791.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	690.00	0.00			

TOTAL ANCILLARY	334,388.71	16,623.00
TOTAL ACCOMODATIONS	138,619.00	0.00
TOTAL CHARGES	473,007.71	16,623.00

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022320000650	11/04/22 - 11/09/22	11/21/22	4,621.00	0.00	0.00	0.00	0.00
614	2022341081917	11/17/22 - 11/21/22	12/12/22	2,161.00	0.00	0.00	0.00	0.00
TOTAL				6,782.00	0.00	0.00	0.00	0.00

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,518,249.97	ADJUSTMENTS	83,895.03
COVERED CHARGES	1,338,143.98	CONTRACTUAL ALLOW	1,048,678.10
NON-COVERD CHARGES	180,105.99	TOTAL MEDICAID LIAB	289,465.88
		LESS: COB	191.73
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	289,274.15
		ALL OTHER	241,784.21
		FEE SCHEDULE-LAB	43,167.24
		INJECTABLE DRUGS	4,322.70

TOTAL NUMBER OF CLAIMS 766

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,179.45	2,511.70
MED/SURG SUPPLY	1,716.00	82.28
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,356.00	2,798.00
CT SCAN	328,167.00	47,158.00
PHYSICAL THERAPY	0.00	9,086.00
EKG/ECG	15,929.00	480.00
IV THERAPY	82,611.00	4,558.00
OPERATING ROOM	33,607.00	4,300.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,142.00	343.00
ANESTHESIA	28,730.00	0.00
GI SERVICES	12,062.00	9,371.00
EMERGENCY ROOM	233,994.00	4,052.00
RECOVERY ROOM	22,627.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,383.00
SPEECH PATHOLOGY	6,916.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	463.00	563.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,195.00	3,182.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,853.00	15,893.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,006.00	6,369.65
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30,736.00	3,189.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	18,077.00	368.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,292.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	269,625.50	15,507.50
MRI SERVICES	61,066.00	4,796.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	387.00	0.01
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,976.03	39,468.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	11.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,914.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	14,431.00	2,721.00

TOTAL ANCILLARY	1,338,143.98	180,105.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,338,143.98	180,105.99

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	5923059000299	12/19/22 - 12/19/22	03/06/23	0.00	2,721.00	0.00	0.00	0.00
614	2023094055130	02/27/23 - 02/27/23	04/10/23	3,325.00	0.00	0.00	0.00	783.70
614	2223114008857	12/21/22 - 12/21/22	05/01/23	1,759.00	0.00	0.00	0.00	414.60
614	2023146080171	05/23/23 - 05/23/23	06/05/23	1,759.00	0.00	0.00	0.00	414.60
614	5923153000605	03/20/23 - 03/20/23	06/05/23	2,161.00	0.00	0.00	0.00	509.35
614	5923171000786	05/23/23 - 05/23/23	06/26/23	3,208.00	0.00	0.00	0.00	756.13
614	2023181029372	06/26/23 - 06/26/23	07/03/23	2,219.00	0.00	0.00	0.00	523.02
TOTAL				14,431.00	2,721.00	0.00	0.00	3,401.40

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,296.90	ADJUSTMENTS	0.00
COVERED CHARGES	18,687.40	CONTRACTUAL ALLOW	14,963.24
NON-COVERD CHARGES	7,609.50	TOTAL MEDICAID LIAB	3,724.16
		LESS: COB	3,724.16
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.60	51.60
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	856.00	774.00
CT SCAN	2,493.00	3,221.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	320.00	0.00
IV THERAPY	1,310.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,434.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	489.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,571.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,348.00	380.00
MRI SERVICES	0.00	2,647.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	346.80	46.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,687.40	7,609.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,687.40	7,609.50

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	77,521.41	ADJUSTMENTS	350.00
COVERED CHARGES	74,345.96	CONTRACTUAL ALLOW	69,445.96
NON-COVERD CHARGES	3,175.45	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,900.00

TOTAL NUMBER OF CLAIMS 70

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.85	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,368.00	227.00
CT SCAN	19,883.00	1,639.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	298.00	0.00
IV THERAPY	4,818.00	179.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	66.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,516.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,032.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,453.00	364.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,638.11	766.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	74,345.96	3,175.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,345.96	3,175.45

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	339.00	ADJUSTMENTS	0.00
COVERED CHARGES	339.00	CONTRACTUAL ALLOW	269.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	90.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	249.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	339.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	339.00	0.00

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,099,338.51	ADJUSTMENTS	442,885.08
COVERED CHARGES	37,065,305.51	CONTRACTUAL ALLOW	32,416,129.40
NON-COVERD CHARGES	34,033.00	TOTAL MEDICAID LIAB	4,649,176.11
		LESS: COB	86,756.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,562,419.51

TOTAL NUMBER OF ADMISSIONS 452

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	861	0	2,074,149.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	861	0	2,074,149.00	0.00
SPECIAL CARE SERVICES				
CCU	921	0	6,513,312.00	0.00
ICU	396	0	2,943,552.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,317	0	9,456,864.00	0.00
TOTAL ACCOMODATIONS	2,178	0	11,531,013.00	0.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,861,798.60	0.00
MED/SURG SUPPLY	674,019.89	0.00
LABORATORY-GENERAL	5,027,388.20	0.00
RADIOLOGY-DIAGNOSTIC	531,434.00	0.00
CT SCAN	2,823,523.00	9,641.00
PHYSICAL THERAPY	94,438.00	0.00
EKG/ECG	471,968.00	0.00
IV THERAPY	620,757.00	0.00
OPERATING ROOM	1,261,095.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,088,270.00	0.00
ANESTHESIA	439,420.00	0.00
GI SERVICES	425,829.00	0.00
EMERGENCY ROOM	1,787,016.00	0.00
RECOVERY ROOM	99,273.00	0.00
LABORATORY PATHOLOGIC	280,398.00	0.00
RADIOLOGY THERAPEUTIC	71,080.00	0.00
OCCUPATIONAL THERAPY	23,162.00	0.00
SPEECH PATHOLOGY	41,482.00	0.00
RENAL DIALYSIS	0.00	23,058.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	805.00	0.00
PSYCHIATRIC SERVICES	1,194.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	125,202.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	662,839.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	110,690.10	1,334.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,051,819.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	42,983.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,147,573.33	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	254,490.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	404,565.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	109,780.39	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	25,534,292.51	34,033.00
TOTAL ACCOMODATIONS	11,531,013.00	0.00
TOTAL CHARGES	37,065,305.51	34,033.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	73,351.60	ADJUSTMENTS	0.00
COVERED CHARGES	73,351.60	CONTRACTUAL ALLOW	61,617.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	11,734.60
		LESS: COB	11,734.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	0	0	0.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	21,216.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	21,216.00	0.00
TOTAL ACCOMODATIONS	3	0	21,216.00	0.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,141.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	813.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,356.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,658.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	551.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,352.00	0.00	MRI SERVICES	4,681.00	0.00
IV THERAPY	786.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	122.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,918.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	626.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,586.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,897.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	52,135.60	0.00
TOTAL ACCOMODATIONS	21,216.00	0.00
TOTAL CHARGES	73,351.60	0.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,299,390.71	ADJUSTMENTS	95,967.76
COVERED CHARGES	17,682,848.31	CONTRACTUAL ALLOW	15,873,251.55
NON-COVERD CHARGES	1,616,542.40	TOTAL MEDICAID LIAB	1,809,596.76
		LESS: COB	22,090.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,787,505.80
		ALL OTHER	1,598,646.17
		FEE SCHEDULE-LAB	160,855.96
		INJECTABLE DRUGS	28,003.67

TOTAL NUMBER OF CLAIMS 2,693

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	382,048.40	19.60
MED/SURG SUPPLY	185,258.42	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766,460.00	3,994.00
CT SCAN	3,427,237.00	148,688.00
PHYSICAL THERAPY	197,603.00	18,315.00
EKG/ECG	419,373.00	9,408.00
IV THERAPY	1,248,106.00	45,598.00
OPERATING ROOM	736,173.33	76,543.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	186,445.00	0.00
ANESTHESIA	370,511.00	0.00
GI SERVICES	127,282.67	35,021.33
EMERGENCY ROOM	4,357,548.00	5,373.00
RECOVERY ROOM	116,543.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	447,392.00	119,544.00
OCCUPATIONAL THERAPY	0.00	769.00
SPEECH PATHOLOGY	15,648.00	2,095.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,495.00	2,254.00
PSYCHIATRIC SERVICES	0.00	1,040.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	304,257.00	25,276.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	118,014.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	103,737.20	102,899.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	166,705.00	157,426.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	181,115.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	346,150.22	118,119.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	208,889.00	13,937.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,272,586.50	58,602.00
MRI SERVICES	695,111.00	36,715.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	1,101.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	264,823.00	633,804.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	36,336.57	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,682,848.31	1,616,542.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,682,848.31	1,616,542.40

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	785,766.01	ADJUSTMENTS	0.00
COVERED CHARGES	389,880.91	CONTRACTUAL ALLOW	351,368.15
NON-COVERD CHARGES	395,885.10	TOTAL MEDICAID LIAB	38,512.76
		LESS: COB	38,512.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 61

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,119.90	0.00	OTHER LAB	7,597.00	0.00
MED/SURG SUPPLY	7,336.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,511.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,871.00	38,259.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,383.00	585.00
EKG/ECG	10,440.00	0.00	MRI SERVICES	0.00	11,921.00
IV THERAPY	29,543.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,720.00	16,547.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,466.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,378.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,155.00	324,917.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	9,433.00	1,383.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	685.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,690.00	2,273.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	747.74	0.00			

TOTAL ANCILLARY	389,880.91	395,885.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	389,880.91	395,885.10

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	409,975.40	ADJUSTMENTS	67.13
COVERED CHARGES	386,620.40	CONTRACTUAL ALLOW	377,624.98
NON-COVERD CHARGES	23,355.00	TOTAL MEDICAID LIAB	8,995.42
		LESS: COB	66.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,928.78

TOTAL NUMBER OF CLAIMS 134

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,813.30	0.00
MED/SURG SUPPLY	238.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,822.00	0.00
CT SCAN	15,342.00	15,435.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	15,680.00	784.00
IV THERAPY	19,073.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	507.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	238,899.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,383.00	825.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,040.00	5,200.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,665.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	48,279.00	1,049.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,879.10	62.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	386,620.40	23,355.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	386,620.40	23,355.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,324.80	ADJUSTMENTS	0.00
COVERED CHARGES	7,324.80	CONTRACTUAL ALLOW	7,190.54
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	134.26
		LESS: COB	134.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	271.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	374.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,228.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,426.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,324.80	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,324.80	0.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,739,946.37	ADJUSTMENTS	6,036.91
COVERED CHARGES	2,622,787.51	CONTRACTUAL ALLOW	2,489,975.73
NON-COVERD CHARGES	117,158.86	TOTAL MEDICAID LIAB	132,811.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	132,811.78

TOTAL NUMBER OF CLAIMS 22

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,409.30	0.00
MED/SURG SUPPLY	56,246.27	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,592.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,704.00	1,568.00
IV THERAPY	24,025.00	0.00
OPERATING ROOM	296,027.00	62,194.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	71,578.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	551.00	0.00
RECOVERY ROOM	15,926.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,112,674.00	31,170.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	15,287.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,876.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,940.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	582,927.10	6,939.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	437,311.74	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,622,787.51	117,158.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,622,787.51	117,158.86

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,287.21	ADJUSTMENTS	7,668.34
COVERED CHARGES	66,126.21	CONTRACTUAL ALLOW	26,516.23
NON-COVERD CHARGES	161.00	TOTAL MEDICAID LIAB	39,609.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	39,609.98

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	22	0	5,950.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	22	0	5,950.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	14	0	8,775.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	8,775.00	0.00
TOTAL ACCOMODATIONS	36	0	14,725.00	0.00

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,410.00	161.00	OTHER LAB	594.52	0.00
MED/SURG SUPPLY	1,879.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,038.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,064.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,441.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	314.41	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,387.39	0.00	MRI SERVICES	2,281.96	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,078.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,169.78	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,653.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	650.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,437.73	0.00			

TOTAL ANCILLARY	51,401.21	161.00
TOTAL ACCOMODATIONS	14,725.00	0.00
TOTAL CHARGES	66,126.21	161.00

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	453,022.13	ADJUSTMENTS	27,513.04
COVERED CHARGES	409,695.06	CONTRACTUAL ALLOW	235,299.94
NON-COVERD CHARGES	43,327.07	TOTAL MEDICAID LIAB	174,395.12
		LESS: COB	121.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	174,274.03
		ALL OTHER	153,868.81
		FEE SCHEDULE-LAB	19,761.74
		INJECTABLE DRUGS	643.48

TOTAL NUMBER OF CLAIMS 446

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202.00	8,292.00
MED/SURG SUPPLY	6,093.93	61.96
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,767.06	102.84
CT SCAN	88,913.21	14,826.66
PHYSICAL THERAPY	9,264.36	1,351.02
EKG/ECG	12,765.65	534.78
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,229.60	1,407.36
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,457.35	737.69
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	459.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,443.08	1,488.59
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,945.97	621.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	846.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,300.00	580.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,900.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,610.89	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,995.86	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90,417.37	7,400.48
MRI SERVICES	16,364.48	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,719.00	5,922.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	409,695.06	43,327.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	409,695.06	43,327.07

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,923.56	ADJUSTMENTS	0.00
COVERED CHARGES	3,313.59	CONTRACTUAL ALLOW	1,957.85
NON-COVERD CHARGES	1,609.97	TOTAL MEDICAID LIAB	1,355.74
		LESS: COB	1,355.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	19.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	405.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	106.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,231.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	839.79	68.56
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	401.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,368.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	192.00	261.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	29.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,313.59	1,609.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,313.59	1,609.97

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,977.06	ADJUSTMENTS	770.00
COVERED CHARGES	82,434.13	CONTRACTUAL ALLOW	75,288.16
NON-COVERD CHARGES	4,542.93	TOTAL MEDICAID LIAB	7,145.97
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,145.97

TOTAL NUMBER OF CLAIMS 104

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120.00	761.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	336.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,033.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,871.06	2,827.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78.00	0.00	FEE SCHEDULE LAB	15,427.24	687.25
EKG/ECG	1,440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,735.70	85.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,362.00	181.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29.53	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	82,434.13	4,542.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,434.13	4,542.93

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,474.78	ADJUSTMENTS	0.00
COVERED CHARGES	1,393.64	CONTRACTUAL ALLOW	1,323.64
NON-COVERD CHARGES	81.14	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	64.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	860.69	17.14
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	475.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,393.64	81.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,393.64	81.14

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	959,132.38	ADJUSTMENTS	9,278.53
COVERED CHARGES	903,591.38	CONTRACTUAL ALLOW	469,584.55
NON-COVERD CHARGES	55,541.00	TOTAL MEDICAID LIAB	434,006.83
		LESS: COB	5,325.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	428,681.18

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	101	0	73,540.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	101	0	73,540.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	116	0	162,695.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	116	0	162,695.00	0.00
TOTAL ACCOMODATIONS	217	0	236,235.00	0.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,782.00	31,790.00
MED/SURG SUPPLY	66,234.13	54.00
LABORATORY-GENERAL	80,318.50	16,320.00
RADIOLOGY-DIAGNOSTIC	21,639.00	0.00
CT SCAN	49,772.00	0.00
PHYSICAL THERAPY	5,555.10	0.00
EKG/ECG	4,455.00	1,386.00
IV THERAPY	0.00	0.00
OPERATING ROOM	21,091.68	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	123,168.00	0.00
ANESTHESIA	11,550.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	103,328.00	0.00
RECOVERY ROOM	2,475.00	0.00
LABORATORY PATHOLOGIC	478.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	278.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,220.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,184.00	5,545.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,061.50	446.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,822.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,404.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,190.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,693.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89,350.22	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	306.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	667,356.38	55,541.00
TOTAL ACCOMODATIONS	236,235.00	0.00
TOTAL CHARGES	903,591.38	55,541.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,238,957.08	ADJUSTMENTS	88,561.13
COVERED CHARGES	1,158,044.23	CONTRACTUAL ALLOW	888,876.58
NON-COVERD CHARGES	80,912.85	TOTAL MEDICAID LIAB	269,167.65
		LESS: COB	22.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	269,145.28
		ALL OTHER	237,476.52
		FEE SCHEDULE-LAB	28,244.02
		INJECTABLE DRUGS	3,424.74

TOTAL NUMBER OF CLAIMS 853

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,165.81	17,213.50
MED/SURG SUPPLY	26,396.47	1,299.95
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,561.00	7,012.00
CT SCAN	193,029.00	8,200.00
PHYSICAL THERAPY	11,426.00	1,019.00
EKG/ECG	11,269.00	99.00
IV THERAPY	61,814.00	89.00
OPERATING ROOM	98,436.20	23,987.65
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,392.00	183.00
ANESTHESIA	67,473.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	253,497.50	462.00
RECOVERY ROOM	18,975.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	372.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	39,893.00	2,441.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,304.00	2,654.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,057.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,636.00	936.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,499.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,263.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	177,614.50	6,195.25
MRI SERVICES	52,261.00	1,500.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,534.50	7,249.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	102.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	445.00	0.00

TOTAL ANCILLARY	1,158,044.23	80,912.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,158,044.23	80,912.85

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022161000743	05/31/22 - 05/31/22	06/13/22	89.00	0.00	0.00	0.00	20.52
780	2022321067403	10/31/22 - 10/31/22	11/21/22	89.00	0.00	0.00	0.00	20.52
780	2023073050184	01/21/23 - 01/21/23	03/20/23	89.00	0.00	0.00	0.00	20.52
780	5923093000257	03/13/23 - 03/13/23	04/10/23	89.00	0.00	0.00	0.00	20.52
780	5023118951005	03/22/23 - 03/22/23	05/01/23	89.00	0.00	0.00	0.00	20.52
TOTAL				445.00	0.00	0.00	0.00	102.60

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,952.56	ADJUSTMENTS	0.00
COVERED CHARGES	1,926.56	CONTRACTUAL ALLOW	1,508.50
NON-COVERD CHARGES	26.00	TOTAL MEDICAID LIAB	418.06
		LESS: COB	418.06
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	650.00	26.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	218.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	366.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	610.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,926.56	26.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,926.56	26.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,042.88	ADJUSTMENTS	156.64
COVERED CHARGES	35,071.88	CONTRACTUAL ALLOW	31,669.72
NON-COVERD CHARGES	971.00	TOTAL MEDICAID LIAB	3,402.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,402.16

TOTAL NUMBER OF CLAIMS 44

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200.00	250.00
MED/SURG SUPPLY	968.88	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,443.00	433.00
CT SCAN	5,750.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	436.00	0.00
IV THERAPY	3,314.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,375.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,710.00	52.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	875.00	236.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,071.88	971.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,071.88	971.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,009,643.18	ADJUSTMENTS	1,087,170.37
COVERED CHARGES	40,687,678.63	CONTRACTUAL ALLOW	30,242,372.69
NON-COVERD CHARGES	321,964.55	TOTAL MEDICAID LIAB	10,445,305.94
		LESS: COB	161,766.11
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,283,539.83

TOTAL NUMBER OF ADMISSIONS 1,109

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,558	0	3,193,327.02	0.00
ROUTINE NURSERY	339	0	805,241.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,897	0	3,998,568.02	0.00
SPECIAL CARE SERVICES				
CCU	318	0	559,998.00	0.00
ICU	1,504	0	2,092,584.29	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,822	0	2,652,582.29	0.00
TOTAL ACCOMODATIONS	5,719	0	6,651,150.31	0.00

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,571,935.78	0.00
MED/SURG SUPPLY	2,362,514.55	320.55
LABORATORY-GENERAL	5,074,443.20	0.00
RADIOLOGY-DIAGNOSTIC	367,488.74	0.00
CT SCAN	2,340,690.92	20,638.00
PHYSICAL THERAPY	118,419.06	0.00
EKG/ECG	191,930.00	0.00
IV THERAPY	760,119.00	0.00
OPERATING ROOM	2,518,785.00	0.00
LABOR/DELIVERY ROOM	454,701.00	0.00
RESPIRATORY SERVICES	1,682,144.00	0.00
ANESTHESIA	853,307.00	0.00
GI SERVICES	279,030.00	0.00
EMERGENCY ROOM	997,075.00	0.00
RECOVERY ROOM	422,664.00	0.00
LABORATORY PATHOLOGIC	102,802.00	0.00
RADIOLOGY THERAPEUTIC	14,518.00	0.00
OCCUPATIONAL THERAPY	82,513.58	0.00
SPEECH PATHOLOGY	49,354.20	0.00
RENAL DIALYSIS	263,250.00	1,140.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,208.00	544.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	207,053.00	5,673.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	509,738.00	185,200.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	31,602.00	11,147.00
AUDIOLOGY	48,610.00	0.00
CARDIOLOGY	2,088,553.66	0.00
AMBULATORY SURGERY	11,094.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,514.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	988,315.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	176,824.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	47,842.00	0.00
OTHER THERAPEUTIC SVC	0.00	178.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	276,337.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	97,124.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,117,152.63	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,036,528.32	321,964.55
TOTAL ACCOMODATIONS	6,651,150.31	0.00
TOTAL CHARGES	40,687,678.63	321,964.55

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	251,753.51	ADJUSTMENTS	0.00
COVERED CHARGES	251,753.51	CONTRACTUAL ALLOW	201,524.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	50,228.70
		LESS: COB	50,228.70
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	48	0	54,346.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	48	0	54,346.00	0.00
SPECIAL CARE SERVICES				
CCU	1	0	1,761.00	0.00
ICU	1	0	1,761.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	3,522.00	0.00
TOTAL ACCOMODATIONS	50	0	57,868.00	0.00

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,054.75	0.00	OTHER LAB	3,409.00	0.00
MED/SURG SUPPLY	28,122.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	41,853.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,717.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,328.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,597.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	980.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,090.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,429.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,646.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,422.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,091.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,861.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	350.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,625.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	130.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,128.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,361.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	691.00	0.00			

TOTAL ANCILLARY	193,885.51	0.00
TOTAL ACCOMODATIONS	57,868.00	0.00
TOTAL CHARGES	251,753.51	0.00

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,856,401.72	ADJUSTMENTS	685,619.91
COVERED CHARGES	20,578,504.13	CONTRACTUAL ALLOW	15,997,069.82
NON-COVERD CHARGES	2,277,897.59	TOTAL MEDICAID LIAB	4,581,434.31
		LESS: COB	3,638.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,577,795.78
		ALL OTHER	2,887,101.27
		FEE SCHEDULE-LAB	516,640.33
		INJECTABLE DRUGS	1,174,054.18

TOTAL NUMBER OF CLAIMS 9,038

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,169.50	175.50
MED/SURG SUPPLY	346,710.15	258.52
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	569,220.00	22,621.00
CT SCAN	2,463,637.00	367,109.00
PHYSICAL THERAPY	0.00	11,540.00
EKG/ECG	270,019.00	9,212.00
IV THERAPY	1,017,338.00	140,931.00
OPERATING ROOM	703,902.80	307,785.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	78,831.00	66,644.00
ANESTHESIA	535,556.00	2,238.00
GI SERVICES	175,060.00	42,321.00
EMERGENCY ROOM	2,159,189.00	20,451.00
RECOVERY ROOM	654,213.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	534,585.00	14,228.00
OCCUPATIONAL THERAPY	0.00	4,830.00
SPEECH PATHOLOGY	490.00	5,245.00
RENAL DIALYSIS	0.00	9,720.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,456.00	1,842.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	524,245.00	50,435.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	99,975.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	228,544.00	34,947.00
AUDIOLOGY	0.00	390.00
CARDIOLOGY	283,209.00	136,370.00
AMBULATORY SURGERY	5,792.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	100,054.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	810,203.00	117,291.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	181,963.00	1,812.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,547.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,624,568.00	165,236.00
MRI SERVICES	386,840.00	72,819.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	226.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	13,264.50	6,282.25
INJECTABLE DRUGS	4,325,232.75	648,125.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	87,237.43	15,265.52
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,578,504.13	2,277,897.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,578,504.13	2,277,897.59

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	272,099.67	ADJUSTMENTS	0.00
COVERED CHARGES	168,034.42	CONTRACTUAL ALLOW	138,023.17
NON-COVERD CHARGES	104,065.25	TOTAL MEDICAID LIAB	30,011.25
		LESS: COB	30,011.25
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 94

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,823.00	0.00
MED/SURG SUPPLY	1,029.92	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,500.00	213.00
CT SCAN	14,785.00	31,897.00
PHYSICAL THERAPY	0.00	586.00
EKG/ECG	2,548.00	0.00
IV THERAPY	17,042.00	4,422.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	944.00
ANESTHESIA	3,831.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,574.00	390.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,153.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,707.00	11,346.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,241.00	2,927.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	839.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,038.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,326.00	3,604.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,005.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	50,606.00	4,779.00
MRI SERVICES	2,158.00	7,554.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,828.50	35,403.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	168,034.42	104,065.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,034.42	104,065.25

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	538,040.03	ADJUSTMENTS	604.17
COVERED CHARGES	502,587.69	CONTRACTUAL ALLOW	473,930.31
NON-COVERD CHARGES	35,452.34	TOTAL MEDICAID LIAB	28,657.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	28,657.38

TOTAL NUMBER OF CLAIMS 428

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,667.25	0.00
MED/SURG SUPPLY	740.44	133.09
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,182.00	739.00
CT SCAN	70,322.00	17,762.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	14,308.00	0.00
IV THERAPY	16,637.00	746.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	194.00	0.00
ANESTHESIA	352.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220,075.00	1,700.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	130.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,617.00	1,797.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	613.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,380.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	906.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	132,423.00	8,108.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,041.00	4,467.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	502,587.69	35,452.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	502,587.69	35,452.34

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,352.75	ADJUSTMENTS	0.00
COVERED CHARGES	8,052.25	CONTRACTUAL ALLOW	7,582.34
NON-COVERD CHARGES	300.50	TOTAL MEDICAID LIAB	469.91
		LESS: COB	469.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41.75	0.00
MED/SURG SUPPLY	274.00	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	196.00	0.00
IV THERAPY	540.00	164.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	292.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,845.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	456.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	453.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,941.00	72.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.50	64.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,052.25	300.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,052.25	300.50

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,880,590.11	ADJUSTMENTS	286,529.34
COVERED CHARGES	9,326,901.70	CONTRACTUAL ALLOW	7,869,462.93
NON-COVERD CHARGES	1,553,688.41	TOTAL MEDICAID LIAB	1,457,438.77
		LESS: COB	1,075.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,456,362.93

TOTAL NUMBER OF CLAIMS 261

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,162.50	0.00
MED/SURG SUPPLY	293,480.62	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,284.00	20,356.00
CT SCAN	29,038.00	7,730.00
PHYSICAL THERAPY	0.00	8,232.00
EKG/ECG	3,528.00	2,940.00
IV THERAPY	94,966.00	6,372.00
OPERATING ROOM	1,047,150.42	513,059.08
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,716.00	2,617.00
ANESTHESIA	417,600.00	2,049.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,497.00	131.00
RECOVERY ROOM	560,553.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	514,215.00	30,970.00
OCCUPATIONAL THERAPY	0.00	1,548.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	972.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	130.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,020.00	1,034.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,520.00	3,274.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	2,927.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	310,112.00	483,791.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	46,974.00	13,035.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,374.00	30,366.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	238.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	75,673.00	3,021.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,330,665.50	183,955.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	6,509.00
IMPL DEV CHARGE PATIENTS	2,444,242.66	228,561.64
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,326,901.70	1,553,688.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,326,901.70	1,553,688.41

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

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,742,021.99	ADJUSTMENTS	2,738,577.08
COVERED CHARGES	30,459,427.54	CONTRACTUAL ALLOW	24,848,156.20
NON-COVERD CHARGES	282,594.45	TOTAL MEDICAID LIAB	5,611,271.34
		LESS: COB	50,623.70
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,709.00
		REIMBURSEMENT	5,563,356.64

TOTAL NUMBER OF ADMISSIONS 691

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,851	0	8,868,687.00	0.00
ROUTINE NURSERY	108	0	175,918.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,959	0	9,044,605.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	512	0	3,468,021.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	512	0	3,468,021.00	0.00
TOTAL ACCOMODATIONS	4,471	0	12,512,626.00	0.00

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,627,505.49	46,264.10
MED/SURG SUPPLY	721,254.24	1,360.85
LABORATORY-GENERAL	4,648,281.73	19,377.50
RADIOLOGY-DIAGNOSTIC	320,797.00	456.00
CT SCAN	937,069.00	12,314.00
PHYSICAL THERAPY	461,623.00	0.00
EKG/ECG	128,595.00	204.00
IV THERAPY	99,912.00	8,447.00
OPERATING ROOM	1,459,603.50	0.00
LABOR/DELIVERY ROOM	88,451.00	0.00
RESPIRATORY SERVICES	1,300,798.37	0.00
ANESTHESIA	317,564.00	0.00
GI SERVICES	70,105.50	0.00
EMERGENCY ROOM	1,461,314.00	2,636.00
RECOVERY ROOM	201,307.00	0.00
LABORATORY PATHOLOGIC	54,364.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	235,540.00	791.00
SPEECH PATHOLOGY	48,515.00	0.00
RENAL DIALYSIS	242,165.00	14,086.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,876.00	392.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	170,172.00	8,624.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	125,778.00	126,910.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,348.00	16,561.00
AUDIOLOGY	0.00	22,567.75
CARDIOLOGY	949,110.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,524.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	105,834.53	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	172,309.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	888.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	156,269.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,385,431.55	1,603.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	381,500.63	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	12,996.00	0.00

TOTAL ANCILLARY	17,946,801.54	282,594.45
TOTAL ACCOMODATIONS	12,512,626.00	0.00
TOTAL CHARGES	30,459,427.54	282,594.45

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2223069001723	01/27/23 - 01/29/23	03/13/23	2,296.00	0.00	0.00	0.00	0.00
615	2023086054695	03/11/23 - 03/14/23	04/03/23	2,296.00	0.00	0.00	0.00	0.00
615	2023284074822	02/08/23 - 02/10/23	10/16/23	2,296.00	0.00	0.00	0.00	0.00
615	5224150000638	07/21/23 - 07/24/23	06/10/24	3,812.00	0.00	0.00	0.00	0.00
615	2124156000024	08/17/23 - 09/07/23	06/10/24	2,296.00	0.00	0.00	0.00	0.00
TOTAL				12,996.00	0.00	0.00	0.00	0.00

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,081.08	ADJUSTMENTS	0.00
COVERED CHARGES	64,932.08	CONTRACTUAL ALLOW	50,476.90
NON-COVERD CHARGES	2,149.00	TOTAL MEDICAID LIAB	14,455.18
		LESS: COB	14,707.18
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	252.00
		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	7	0	16,753.00	0.00
ROUTINE NURSERY	9	0	14,412.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16	0	31,165.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	16	0	31,165.00	0.00

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,844.25	0.00
MED/SURG SUPPLY	834.83	0.00
LABORATORY-GENERAL	15,433.25	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	3,351.00	0.00
LABOR/DELIVERY ROOM	4,254.75	0.00
RESPIRATORY SERVICES	2,770.00	0.00
ANESTHESIA	274.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	575.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	556.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	2,149.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	404.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,318.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,767.08	2,149.00
TOTAL ACCOMODATIONS	31,165.00	0.00
TOTAL CHARGES	64,932.08	2,149.00

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,984,457.32	ADJUSTMENTS	444,291.34
COVERED CHARGES	10,687,054.93	CONTRACTUAL ALLOW	8,790,192.98
NON-COVERD CHARGES	1,297,402.39	TOTAL MEDICAID LIAB	1,896,861.95
		LESS: COB	7,181.85
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,889,680.10
		ALL OTHER	1,690,632.90
		FEE SCHEDULE-LAB	184,789.28
		INJECTABLE DRUGS	14,257.92

TOTAL NUMBER OF CLAIMS 3,765

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,715.25	14,705.18
MED/SURG SUPPLY	162,043.21	15,503.65
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251,723.00	14,257.00
CT SCAN	912,977.00	295,643.00
PHYSICAL THERAPY	252,091.00	127,860.00
EKG/ECG	140,747.00	12,186.00
IV THERAPY	771,384.00	1,645.00
OPERATING ROOM	689,100.25	282,707.75
LABOR/DELIVERY ROOM	9,239.75	0.00
RESPIRATORY SERVICES	47,033.00	3,038.00
ANESTHESIA	236,767.00	0.00
GI SERVICES	84,167.75	7,641.00
EMERGENCY ROOM	3,109,053.75	7,174.75
RECOVERY ROOM	332,133.00	7,208.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	35,537.00	31,812.00
SPEECH PATHOLOGY	3,549.00	4,311.00
RENAL DIALYSIS	0.00	1,826.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,330.18	788.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	901.00	0.00
OTHER IMAGING SERVICE	219,535.00	25,142.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,764.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	48,159.00	27,136.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	257,855.00	130,321.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	295,295.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	116,063.04	17,819.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	249,655.00	5,019.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	433.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,925,359.25	75,574.50
MRI SERVICES	208,653.00	19,386.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	153,920.05	82,436.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	56,304.45	85,829.06
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,687,054.93	1,297,402.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,687,054.93	1,297,402.39

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	185,528.18	ADJUSTMENTS	0.00
COVERED CHARGES	137,938.32	CONTRACTUAL ALLOW	119,393.72
NON-COVERD CHARGES	47,589.86	TOTAL MEDICAID LIAB	18,544.60
		LESS: COB	18,544.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 42

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	791.75	207.00
MED/SURG SUPPLY	1,933.32	69.86
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,027.00	351.00
CT SCAN	9,452.00	17,849.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,399.00	0.00
IV THERAPY	8,966.00	0.00
OPERATING ROOM	0.00	2,765.00
LABOR/DELIVERY ROOM	202.75	0.00
RESPIRATORY SERVICES	237.00	0.00
ANESTHESIA	2,580.00	0.00
GI SERVICES	5,094.00	0.00
EMERGENCY ROOM	50,875.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	314.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	210.00	2,188.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	21,420.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,784.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,596.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,999.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,516.50	1,925.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,155.00	291.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,120.00	210.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	137,938.32	47,589.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,938.32	47,589.86

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	480,206.67	ADJUSTMENTS	1,409.73
COVERED CHARGES	466,677.67	CONTRACTUAL ALLOW	440,899.75
NON-COVERD CHARGES	13,529.00	TOTAL MEDICAID LIAB	25,777.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,777.92

TOTAL NUMBER OF CLAIMS 384

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,664.50	187.25
MED/SURG SUPPLY	618.92	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,215.00	0.00
CT SCAN	18,858.00	7,617.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,530.00	0.00
IV THERAPY	26,335.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	331.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	344,817.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,118.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	47,869.50	5,398.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,320.75	326.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	466,677.67	13,529.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	466,677.67	13,529.00

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,114.50	ADJUSTMENTS	0.00
COVERED CHARGES	30,986.25	CONTRACTUAL ALLOW	30,382.08
NON-COVERD CHARGES	6,128.25	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39.50	10.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,418.00	0.00
CT SCAN	1,976.00	5,784.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	847.00	0.00
IV THERAPY	2,175.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	254.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,700.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,118.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,047.00	325.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	411.75	9.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	30,986.25	6,128.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,986.25	6,128.25

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,168,275.68	ADJUSTMENTS	15,756.79
COVERED CHARGES	1,668,285.81	CONTRACTUAL ALLOW	1,431,065.26
NON-COVERD CHARGES	499,989.87	TOTAL MEDICAID LIAB	237,220.55
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	237,220.55

TOTAL NUMBER OF CLAIMS 45

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,423.75	4,359.15
MED/SURG SUPPLY	115,789.88	851.94
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,413.00	1,347.00
CT SCAN	0.00	3,959.00
PHYSICAL THERAPY	0.00	26,161.00
EKG/ECG	612.00	0.00
IV THERAPY	6,571.00	0.00
OPERATING ROOM	832,643.00	41,889.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,962.00	0.00
ANESTHESIA	172,976.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,647.00	0.00
RECOVERY ROOM	245,143.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	13,563.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,691.00	1,304.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,201.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,975.00	46,418.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,272.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,624.00	1,946.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,483.50	6,296.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	92,858.68	351,895.23
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,668,285.81	499,989.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,668,285.81	499,989.87

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,371.15	ADJUSTMENTS	0.00
COVERED CHARGES	33,159.89	CONTRACTUAL ALLOW	27,907.46
NON-COVERD CHARGES	18,211.26	TOTAL MEDICAID LIAB	5,252.43
		LESS: COB	5,252.43
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.00	32.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,545.89	540.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	373.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	781.00	FEE SCHEDULE LAB	449.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,800.00	2,578.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,255.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,905.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,120.00	14,280.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,304.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	33,159.89	18,211.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,159.89	18,211.26

** END OF REPORT **

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,564,736.70	ADJUSTMENTS	474,923.18
COVERED CHARGES	27,366,809.60	CONTRACTUAL ALLOW	21,749,734.69
NON-COVERD CHARGES	197,927.10	TOTAL MEDICAID LIAB	5,617,074.91
		LESS: COB	59,293.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,557,781.63

TOTAL NUMBER OF ADMISSIONS 388

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,627	0	2,119,555.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,627	0	2,119,555.00	0.00
SPECIAL CARE SERVICES				
CCU	208	0	908,811.23	0.00
ICU	1,233	0	3,253,066.75	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,441	0	4,161,877.98	0.00
TOTAL ACCOMODATIONS	3,068	0	6,281,432.98	0.00

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,586,009.00	17,756.00
MED/SURG SUPPLY	691,512.00	846.00
LABORATORY-GENERAL	2,956,534.36	0.00
RADIOLOGY-DIAGNOSTIC	686,386.90	0.00
CT SCAN	1,257,231.00	44,026.00
PHYSICAL THERAPY	370,399.00	0.00
EKG/ECG	114,485.00	0.00
IV THERAPY	381,194.00	0.00
OPERATING ROOM	3,211,375.88	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,866,979.00	0.00
ANESTHESIA	539,939.62	0.00
GI SERVICES	111,231.00	0.00
EMERGENCY ROOM	789,774.18	0.00
RECOVERY ROOM	318,363.42	0.00
LABORATORY PATHOLOGIC	59,880.00	0.00
RADIOLOGY THERAPEUTIC	23,212.76	0.00
OCCUPATIONAL THERAPY	120,673.00	0.00
SPEECH PATHOLOGY	125,848.23	0.00
RENAL DIALYSIS	298,247.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	49.00	434.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	151,821.16	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	282,133.00	47,832.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	145,101.58	77,803.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	699,915.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	85,553.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	178,113.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	106,704.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	9,229.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	202,691.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,373,212.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,350,806.06	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,085,376.62	197,927.10
TOTAL ACCOMODATIONS	6,281,432.98	0.00
TOTAL CHARGES	27,366,809.60	197,927.10

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,288.03	ADJUSTMENTS	0.00
COVERED CHARGES	91,288.03	CONTRACTUAL ALLOW	82,384.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,903.44
		LESS: COB	8,903.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	22	0	28,666.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	22	0	28,666.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	22	0	28,666.00	0.00

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,356.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	575.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,024.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,538.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,873.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,026.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,002.74	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	684.42	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,069.58	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,031.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,093.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,756.39	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,321.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	62,622.03	0.00
TOTAL ACCOMODATIONS	28,666.00	0.00
TOTAL CHARGES	91,288.03	0.00

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,261,531.44	ADJUSTMENTS	189,937.06
COVERED CHARGES	9,504,555.28	CONTRACTUAL ALLOW	8,215,179.53
NON-COVERD CHARGES	1,756,976.16	TOTAL MEDICAID LIAB	1,289,375.75
		LESS: COB	1,285.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,288,090.66
		ALL OTHER	1,138,550.03
		FEE SCHEDULE-LAB	126,199.51
		INJECTABLE DRUGS	23,341.12

TOTAL NUMBER OF CLAIMS 3,282

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,709.00	42,044.00
MED/SURG SUPPLY	191,325.00	34,103.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350,912.95	83,817.00
CT SCAN	1,132,420.00	51,934.00
PHYSICAL THERAPY	64,721.60	27,521.90
EKG/ECG	84,510.00	10,530.00
IV THERAPY	497,244.00	74,267.00
OPERATING ROOM	1,952,878.82	307,922.41
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	120,995.10	267.00
ANESTHESIA	378,241.20	0.00
GI SERVICES	92,167.54	7,508.90
EMERGENCY ROOM	1,294,385.24	37,784.74
RECOVERY ROOM	149,867.04	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,580.00	317.00
SPEECH PATHOLOGY	699.40	2,713.18
RENAL DIALYSIS	0.00	6,171.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	35,041.65	418.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	128,831.62	9,097.46
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,175.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	385,675.35	368,256.04
AUDIOLOGY	33,267.48	2,856.00
CARDIOLOGY	356,379.10	118,418.55
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,947.00	1,236.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	116,760.67	2,646.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	69,300.06	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	367.50
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,095,535.66	75,846.38
MRI SERVICES	317,435.00	63,130.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	206,927.00	70,614.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	294,622.00	357,188.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,504,555.28	1,756,976.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,504,555.28	1,756,976.16

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	304,920.54	ADJUSTMENTS	0.00
COVERED CHARGES	159,970.36	CONTRACTUAL ALLOW	139,309.39
NON-COVERD CHARGES	144,950.18	TOTAL MEDICAID LIAB	20,660.97
		LESS: COB	20,660.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,293.00	298.00
MED/SURG SUPPLY	31,663.00	451.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,191.95	2,366.00
CT SCAN	3,211.00	15,619.00
PHYSICAL THERAPY	0.00	1,235.00
EKG/ECG	1,890.00	0.00
IV THERAPY	9,458.00	0.00
OPERATING ROOM	14,129.38	44,992.88
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	14,749.20	0.00
GI SERVICES	0.00	4,139.16
EMERGENCY ROOM	28,823.30	0.00
RECOVERY ROOM	9,183.06	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,631.48	1,812.54
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,567.90	6,096.00
AUDIOLOGY	2,082.50	0.00
CARDIOLOGY	0.00	13,554.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,952.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,118.69	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,142.90	701.60
MRI SERVICES	2,022.00	2,487.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,732.00	3,267.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,129.00	47,931.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	159,970.36	144,950.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,970.36	144,950.18

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	159,439.45	ADJUSTMENTS	201.39
COVERED CHARGES	154,274.45	CONTRACTUAL ALLOW	149,373.96
NON-COVERD CHARGES	5,165.00	TOTAL MEDICAID LIAB	4,900.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,900.49

TOTAL NUMBER OF CLAIMS 73

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	976.00	0.00
MED/SURG SUPPLY	8,952.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,213.85	0.00
CT SCAN	12,740.00	1,473.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,350.00	0.00
IV THERAPY	11,419.00	2,314.00
OPERATING ROOM	13,744.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,366.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	67,246.30	0.00
RECOVERY ROOM	2,234.82	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,428.46	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	761.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,963.52	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,222.00	48.00
MRI SERVICES	3,108.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,549.00	1,330.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	154,274.45	5,165.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	154,274.45	5,165.00

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,247.55	ADJUSTMENTS	0.00
COVERED CHARGES	9,568.95	CONTRACTUAL ALLOW	9,300.43
NON-COVERD CHARGES	6,678.60	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160.00	240.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	498.75	0.00
CT SCAN	0.00	5,400.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	270.00	270.00
IV THERAPY	3,775.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,414.40	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,264.80	677.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	186.00	91.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,568.95	6,678.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,568.95	6,678.60

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,090,281.91	ADJUSTMENTS	34,511.76
COVERED CHARGES	1,733,886.32	CONTRACTUAL ALLOW	1,572,831.44
NON-COVERD CHARGES	356,395.59	TOTAL MEDICAID LIAB	161,054.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	161,054.88

TOTAL NUMBER OF CLAIMS 28

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

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,773.00	2,566.00
MED/SURG SUPPLY	154,361.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,493.55	7,474.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	14,887.00
EKG/ECG	3,240.00	1,080.00
IV THERAPY	1,264.00	684.00
OPERATING ROOM	371,898.61	69,266.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	108,810.88	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	57,074.58	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,548.40	2,011.08
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,963.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	74,689.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,200.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,803.30	381.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,826.00	22,758.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	952,630.00	160,599.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,733,886.32	356,395.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,733,886.32	356,395.59

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,032,993.50	ADJUSTMENTS	1,914,028.17
COVERED CHARGES	29,676,808.48	CONTRACTUAL ALLOW	23,200,823.86
NON-COVERD CHARGES	356,185.02	TOTAL MEDICAID LIAB	6,475,984.62
		LESS: COB	15,827.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,460,157.61

TOTAL NUMBER OF ADMISSIONS 418

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,462	0	4,457,024.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,462	0	4,457,024.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	671	0	4,727,651.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	671	0	4,727,651.00	0.00
TOTAL ACCOMODATIONS	3,133	0	9,184,675.00	0.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,842,752.34	0.00
MED/SURG SUPPLY	834,199.92	172,667.00
LABORATORY-GENERAL	4,062,767.31	0.00
RADIOLOGY-DIAGNOSTIC	256,498.00	0.00
CT SCAN	846,667.00	10,609.00
PHYSICAL THERAPY	161,422.00	0.00
EKG/ECG	121,504.00	0.00
IV THERAPY	129,780.00	0.00
OPERATING ROOM	3,118,739.01	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,125,589.00	0.00
ANESTHESIA	557,939.00	0.00
GI SERVICES	262,040.00	3,472.00
EMERGENCY ROOM	858,611.00	0.00
RECOVERY ROOM	114,130.00	0.00
LABORATORY PATHOLOGIC	112,797.00	0.00
RADIOLOGY THERAPEUTIC	26,449.00	0.00
OCCUPATIONAL THERAPY	125,368.00	0.00
SPEECH PATHOLOGY	64,364.00	0.00
RENAL DIALYSIS	332,820.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	437.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	125,289.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	244,604.00	110,263.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	52,663.00	4,561.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,489,569.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	56,113.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	721,363.00	20,000.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	181,815.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,806.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	149,536.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	26,928.77
INJECTABLE DRUGS	903,812.16	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	2,878.00
IMPL DEV CHARGE PATIENTS	517,332.74	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	95,163.00	0.00

TOTAL ANCILLARY	20,492,133.48	356,185.02
TOTAL ACCOMODATIONS	9,184,675.00	0.00
TOTAL CHARGES	29,676,808.48	356,185.02

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022306028519	10/16/22 - 10/22/22	11/07/22	3,812.00	0.00	0.00	0.00	0.00
615	2022360012820	12/19/22 - 12/21/22	01/02/23	7,624.00	0.00	0.00	0.00	0.00
614	5923002000160	10/12/22 - 10/20/22	01/09/23	2,115.00	0.00	0.00	0.00	0.00
615	2023016023573	01/02/23 - 01/10/23	01/23/23	7,624.00	0.00	0.00	0.00	0.00
614	2023024055007	01/03/23 - 01/16/23	01/30/23	7,624.00	0.00	0.00	0.00	0.00
614	2023039000059	01/25/23 - 02/01/23	02/13/23	2,296.00	0.00	0.00	0.00	0.00
614	5223046000280	10/04/22 - 10/11/22	02/20/23	7,624.00	0.00	0.00	0.00	0.00
615	5923072001339	01/29/23 - 02/06/23	03/20/23	7,624.00	0.00	0.00	0.00	0.00
614	2023080000445	03/12/23 - 03/15/23	03/27/23	3,812.00	0.00	0.00	0.00	0.00
614	5223099000025	02/15/23 - 02/27/23	04/17/23	2,296.00	0.00	0.00	0.00	0.00
614	5223120090185	02/23/23 - 03/08/23	05/08/23	3,812.00	0.00	0.00	0.00	0.00
615	2023135038768	05/07/23 - 05/10/23	05/22/23	7,624.00	0.00	0.00	0.00	0.00
615	2023136081711	05/09/23 - 05/12/23	05/22/23	7,624.00	0.00	0.00	0.00	0.00
614	5223162000017	01/28/23 - 03/08/23	06/19/23	3,812.00	0.00	0.00	0.00	0.00
615	5223172000265	05/01/23 - 05/11/23	06/26/23	7,624.00	0.00	0.00	0.00	0.00
615	5223208000307	07/03/23 - 07/11/23	07/31/23	7,624.00	0.00	0.00	0.00	0.00
615	2023228070939	08/05/23 - 08/13/23	08/21/23	4,592.00	0.00	0.00	0.00	0.00
TOTAL				95,163.00	0.00	0.00	0.00	0.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,825.62	ADJUSTMENTS	0.00
COVERED CHARGES	103,193.62	CONTRACTUAL ALLOW	76,406.28
NON-COVERD CHARGES	632.00	TOTAL MEDICAID LIAB	26,787.34
		LESS: COB	26,787.34
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	26	0	46,982.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	26	0	46,982.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	26	0	46,982.00	0.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,280.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	704.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,105.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,556.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,743.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,224.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,895.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	992.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,149.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,873.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,552.00	0.00	INJECTABLE DRUGS	4,393.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	508.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	108.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	632.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,128.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	56,211.62	632.00
TOTAL ACCOMODATIONS	46,982.00	0.00
TOTAL CHARGES	103,193.62	632.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,702,812.90	ADJUSTMENTS	39,659.69
COVERED CHARGES	4,997,588.28	CONTRACTUAL ALLOW	4,134,768.02
NON-COVERD CHARGES	1,705,224.62	TOTAL MEDICAID LIAB	862,820.26
		LESS: COB	6,171.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	856,648.40
		ALL OTHER	781,796.79
		FEE SCHEDULE-LAB	67,999.82
		INJECTABLE DRUGS	6,851.79

TOTAL NUMBER OF CLAIMS 1,406

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,219.48	94,058.53
MED/SURG SUPPLY	163,261.24	10,395.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,962.00	42,448.00
CT SCAN	492,024.00	155,499.00
PHYSICAL THERAPY	0.00	3,221.00
EKG/ECG	60,384.00	1,020.00
IV THERAPY	103,114.00	6,378.00
OPERATING ROOM	527,697.22	327,709.79
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,426.00	6,795.00
ANESTHESIA	240,476.00	0.00
GI SERVICES	93,972.00	122,036.00
EMERGENCY ROOM	959,924.00	14,343.00
RECOVERY ROOM	173,987.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	74,410.00	103,022.00
OCCUPATIONAL THERAPY	0.00	2,365.00
SPEECH PATHOLOGY	0.00	1,598.00
RENAL DIALYSIS	0.00	6,956.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	216.00	324.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	293,020.00	60,051.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,363.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	71,452.00	84,110.45
AUDIOLOGY	0.00	0.00
CARDIOLOGY	234,122.00	361,810.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,260.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	186,702.00	4,444.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	214,242.00	1,881.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	112.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	654,729.20	58,314.00
MRI SERVICES	132,678.00	21,034.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,122.41
INJECTABLE DRUGS	53,403.11	28,776.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	10,406.03	167,857.22
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	37,138.00	17,544.00

TOTAL ANCILLARY	4,997,588.28	1,705,224.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,997,588.28	1,705,224.62

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022260027281	09/09/22 - 09/09/22	09/26/22	39.00	0.00	0.00	0.00	20.52
780	2022264075475	09/15/22 - 09/15/22	09/26/22	39.00	0.00	0.00	0.00	20.52
780	2022276057194	09/27/22 - 09/27/22	10/10/22	38.00	0.00	0.00	0.00	20.52
780	2022281027881	09/27/22 - 09/27/22	10/17/22	38.00	0.00	0.00	0.00	20.52
615	2022306099455	10/28/22 - 10/28/22	11/07/22	0.00	2,296.00	0.00	0.00	0.00
780	2022327094214	09/06/22 - 09/06/22	11/28/22	38.00	0.00	0.00	0.00	20.52
614	2022335111148	11/28/22 - 11/28/22	12/05/22	3,812.00	0.00	0.00	0.00	687.49
614	2022342106174	12/05/22 - 12/05/22	12/12/22	3,812.00	0.00	0.00	0.00	687.49
614	2023009045016	01/06/23 - 01/06/23	01/16/23	3,812.00	0.00	0.00	0.00	687.49
780	2023044046794	01/12/23 - 01/12/23	02/20/23	38.00	0.00	0.00	0.00	20.52
614	2023051039323	02/17/23 - 02/17/23	02/27/23	3,812.00	0.00	0.00	0.00	687.49
780	2023058047638	02/24/23 - 02/24/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023059072265	02/24/23 - 02/24/23	03/06/23	38.00	0.00	0.00	0.00	20.52
614	2023067017838	02/03/23 - 02/03/23	03/13/23	0.00	3,812.00	0.00	0.00	0.00
614	2023067017838	02/03/23 - 02/03/23	03/13/23	0.00	3,812.00	0.00	0.00	0.00
780	2023074081749	02/23/23 - 02/23/23	03/20/23	38.00	0.00	0.00	0.00	20.52
614	2023087013377	03/23/23 - 03/23/23	04/03/23	3,812.00	0.00	0.00	0.00	687.49
614	2023089097660	03/27/23 - 03/27/23	04/03/23	3,812.00	0.00	0.00	0.00	687.49
780	2023097087334	04/04/23 - 04/04/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023101016167	03/22/23 - 03/22/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023104084822	03/13/23 - 03/13/23	04/24/23	38.00	0.00	0.00	0.00	20.52
614	2023108007311	04/13/23 - 04/13/23	04/24/23	3,812.00	0.00	0.00	0.00	687.49
780	2023111016304	03/28/23 - 03/28/23	04/24/23	38.00	0.00	0.00	0.00	20.52
614	2223114007009	03/01/23 - 03/01/23	05/01/23	2,296.00	0.00	0.00	0.00	414.09
614	2223118008643	03/03/23 - 03/03/23	05/01/23	3,812.00	0.00	0.00	0.00	687.49
780	2023118090187	04/25/23 - 04/25/23	05/08/23	38.00	0.00	0.00	0.00	20.52
614	2023121049722	04/26/23 - 04/26/23	05/08/23	3,812.00	0.00	0.00	0.00	687.49
615	2223360005384	06/22/23 - 06/22/23	01/01/24	0.00	3,812.00	0.00	0.00	0.00
615	2223360005384	06/22/23 - 06/22/23	01/01/24	0.00	3,812.00	0.00	0.00	0.00
TOTAL				37,138.00	17,544.00	0.00	0.00	6,888.78

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	437,927.28	ADJUSTMENTS	0.00
COVERED CHARGES	257,921.88	CONTRACTUAL ALLOW	211,422.07
NON-COVERD CHARGES	180,005.40	TOTAL MEDICAID LIAB	46,499.81
		LESS: COB	46,499.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 52

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,547.35	2,221.41
MED/SURG SUPPLY	3,286.29	288.54
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,686.00	783.00
CT SCAN	5,248.00	15,527.00
PHYSICAL THERAPY	0.00	1,230.00
EKG/ECG	2,244.00	408.00
IV THERAPY	5,928.00	0.00
OPERATING ROOM	29,819.00	9,966.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,458.00	2,662.00
ANESTHESIA	13,268.00	0.00
GI SERVICES	1,239.00	0.00
EMERGENCY ROOM	52,419.00	0.00
RECOVERY ROOM	2,759.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	9,111.00	78,253.00
OCCUPATIONAL THERAPY	0.00	1,399.00
SPEECH PATHOLOGY	0.00	597.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	780.00	3,501.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	5,128.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	51,465.00	32,477.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,372.00	2,564.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,643.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,488.00	7,602.00
MRI SERVICES	0.00	9,920.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,089.24	2,000.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	11,410.00	3,477.49
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	7,662.00	0.00

TOTAL ANCILLARY	257,921.88	180,005.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	257,921.88	180,005.40

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023118090169	02/22/23 - 02/22/23	05/08/23	38.00	0.00	0.00	20.52	0.00
615	2023229087831	03/25/23 - 03/25/23	08/21/23	3,812.00	0.00	0.00	2,033.68	0.00
615	2023229087831	03/25/23 - 03/25/23	08/21/23	3,812.00	0.00	0.00	2,033.68	0.00
TOTAL				7,662.00	0.00	0.00	4,087.88	0.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	242,958.11	ADJUSTMENTS	134.26
COVERED CHARGES	222,816.18	CONTRACTUAL ALLOW	215,834.66
NON-COVERD CHARGES	20,141.93	TOTAL MEDICAID LIAB	6,981.52
		LESS: COB	18.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,962.92

TOTAL NUMBER OF CLAIMS 104

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143.34	2,420.15
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,621.00	1,556.00
CT SCAN	20,915.00	9,652.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,284.00	0.00
IV THERAPY	13,698.00	816.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	135,290.00	572.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,343.00	2,373.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	718.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,305.00	2,268.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,617.84	484.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	222,816.18	20,141.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	222,816.18	20,141.93

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,556.88	ADJUSTMENTS	0.00
COVERED CHARGES	6,472.88	CONTRACTUAL ALLOW	6,204.36
NON-COVERD CHARGES	84.00	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	970.00	84.00
EKG/ECG	204.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,030.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,472.88	84.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,472.88	84.00

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	954,784.42	ADJUSTMENTS	6,236.90
COVERED CHARGES	811,865.61	CONTRACTUAL ALLOW	706,759.83
NON-COVERD CHARGES	142,918.81	TOTAL MEDICAID LIAB	105,105.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	105,105.78

TOTAL NUMBER OF CLAIMS 17

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,835.35	4,300.05
MED/SURG SUPPLY	58,263.10	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	304.00	0.00
CT SCAN	1,289.00	2,293.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	408.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	366,911.00	67,078.01
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	94.00	0.00
ANESTHESIA	88,349.00	0.00
GI SERVICES	4,184.00	5,021.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	46,846.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	156,539.00	28,975.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,496.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	32,699.00	12,001.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,812.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,384.00	6,204.00
MRI SERVICES	0.00	3,290.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,928.76	769.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,523.40	12,986.95
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	811,865.61	142,918.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	811,865.61	142,918.81

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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,295,925.49	ADJUSTMENTS	46,969.14
COVERED CHARGES	15,074,875.68	CONTRACTUAL ALLOW	11,456,936.32
NON-COVERD CHARGES	221,049.81	TOTAL MEDICAID LIAB	3,617,939.36
		LESS: COB	12,706.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,605,232.74

TOTAL NUMBER OF ADMISSIONS 381

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,234	0	2,314,375.00	0.00
ROUTINE NURSERY	298	0	621,515.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,532	0	2,935,890.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	511	0	1,708,820.00	0.00
NICU	8	0	29,608.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	519	0	1,738,428.00	0.00
TOTAL ACCOMODATIONS	2,051	0	4,674,318.00	0.00

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,215,208.35	3,192.77
MED/SURG SUPPLY	432,737.93	5,004.79
LABORATORY-GENERAL	837,234.24	3,276.00
RADIOLOGY-DIAGNOSTIC	194,744.00	0.00
CT SCAN	392,687.00	178,135.00
PHYSICAL THERAPY	137,995.00	0.00
EKG/ECG	108,567.00	0.00
IV THERAPY	310,315.00	0.00
OPERATING ROOM	1,563,195.00	9,623.00
LABOR/DELIVERY ROOM	121,344.00	0.00
RESPIRATORY SERVICES	783,725.00	0.00
ANESTHESIA	571,092.00	0.00
GI SERVICES	117,236.00	0.00
EMERGENCY ROOM	647,875.00	0.00
RECOVERY ROOM	331,180.00	0.00
LABORATORY PATHOLOGIC	29,619.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	104,467.00	0.00
SPEECH PATHOLOGY	58,651.00	0.00
RENAL DIALYSIS	195,746.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,619.00	375.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	54,555.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	79,177.00	9,919.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,880.00	2,285.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	527,087.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,234.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,199.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	93,758.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	84.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	174,166.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,239.25
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,153,090.16	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	84,090.00	0.00

TOTAL ANCILLARY	10,400,557.68	221,049.81
TOTAL ACCOMODATIONS	4,674,318.00	0.00
TOTAL CHARGES	15,074,875.68	221,049.81

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022216096068	07/19/22 - 07/24/22	08/08/22	4,678.00	0.00	0.00	0.00	0.00
615	2022221065287	07/25/22 - 08/02/22	08/15/22	2,430.00	0.00	0.00	0.00	0.00
614	2022230081360	08/06/22 - 08/10/22	08/22/22	2,704.00	0.00	0.00	0.00	0.00
614	2022236066375	08/07/22 - 08/13/22	08/29/22	7,160.00	0.00	0.00	0.00	0.00
614	2022271077996	09/17/22 - 09/20/22	10/03/22	2,704.00	0.00	0.00	0.00	0.00
615	2022278077944	09/17/22 - 09/25/22	10/10/22	4,873.00	0.00	0.00	0.00	0.00
614	2022292122024	07/22/22 - 07/30/22	10/24/22	4,678.00	0.00	0.00	0.00	0.00
614	2022301092148	10/13/22 - 10/17/22	11/07/22	7,330.00	0.00	0.00	0.00	0.00
614	2022315081524	11/02/22 - 11/07/22	11/21/22	2,701.00	0.00	0.00	0.00	0.00
614	2022328058816	11/08/22 - 11/19/22	11/28/22	10,034.00	0.00	0.00	0.00	0.00
614	2022341080669	11/19/22 - 11/28/22	12/12/22	5,408.00	0.00	0.00	0.00	0.00
614	2022346044337	12/03/22 - 12/07/22	12/19/22	2,704.00	0.00	0.00	0.00	0.00
614	2022363000183	12/12/22 - 12/16/22	01/02/23	2,669.00	0.00	0.00	0.00	0.00
614	2023053000053	11/29/22 - 11/30/22	02/27/23	4,224.00	0.00	0.00	0.00	0.00
614	2023081000089	03/13/23 - 03/15/23	03/27/23	4,224.00	0.00	0.00	0.00	0.00
614	2023081000093	03/12/23 - 03/16/23	03/27/23	4,224.00	0.00	0.00	0.00	0.00
614	2023179031437	05/23/23 - 06/20/23	07/03/23	4,224.00	0.00	0.00	0.00	0.00
615	2023263000194	06/10/23 - 06/18/23	09/25/23	2,443.00	0.00	0.00	0.00	0.00
614	2023278121597	02/22/23 - 03/18/23	10/09/23	4,678.00	0.00	0.00	0.00	0.00
TOTAL				84,090.00	0.00	0.00	0.00	0.00

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,188.84	ADJUSTMENTS	0.00
COVERED CHARGES	39,477.92	CONTRACTUAL ALLOW	29,821.54
NON-COVERD CHARGES	1,710.92	TOTAL MEDICAID LIAB	9,656.38
		LESS: COB	9,656.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	6	0	11,080.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	11,080.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	11,080.00	0.00

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	824.92	1,710.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	804.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,351.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,328.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,909.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,819.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,362.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,397.92	1,710.92
TOTAL ACCOMODATIONS	11,080.00	0.00
TOTAL CHARGES	39,477.92	1,710.92

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,329,280.77	ADJUSTMENTS	213,940.31
COVERED CHARGES	7,924,966.22	CONTRACTUAL ALLOW	6,530,162.33
NON-COVERD CHARGES	1,404,314.55	TOTAL MEDICAID LIAB	1,394,803.89
		LESS: COB	6,000.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,388,803.09
		ALL OTHER	1,159,660.31
		FEE SCHEDULE-LAB	131,628.00
		INJECTABLE DRUGS	97,514.78

TOTAL NUMBER OF CLAIMS 3,224

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,971.17	11,417.30
MED/SURG SUPPLY	50,711.77	14,745.78
LABORATORY-GENERAL	0.00	149.00
RADIOLOGY-DIAGNOSTIC	375,531.00	17,230.00
CT SCAN	776,129.00	172,366.00
PHYSICAL THERAPY	69,656.00	16,220.00
EKG/ECG	174,239.00	18,911.00
IV THERAPY	605,758.00	26,300.00
OPERATING ROOM	590,849.00	344,137.00
LABOR/DELIVERY ROOM	470.00	470.00
RESPIRATORY SERVICES	36,144.00	1,594.00
ANESTHESIA	333,234.00	2,664.00
GI SERVICES	71,558.00	35,392.00
EMERGENCY ROOM	2,281,877.00	12,011.00
RECOVERY ROOM	281,825.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	21,212.00	9,049.00
SPEECH PATHOLOGY	8,312.00	9,089.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	44,389.00	3,777.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	142,624.00	40,029.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,711.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	76,808.00	30,641.80
AUDIOLOGY	0.00	0.00
CARDIOLOGY	183,387.00	59,027.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,080.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	107,422.00	6,270.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	92,832.00	726.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	998.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	670,351.70	42,211.00
MRI SERVICES	235,743.00	33,061.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	559,263.58	232,548.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	256,662.87
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	54,880.00	7,615.00

TOTAL ANCILLARY	7,924,966.22	1,404,314.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,924,966.22	1,404,314.55

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022227042618	07/20/22 - 07/20/22	08/22/22	0.00	2,443.00	0.00	0.00	0.00
615	2022270068460	09/20/22 - 09/20/22	10/03/22	0.00	2,443.00	0.00	0.00	0.00
614	2022322088648	11/15/22 - 11/15/22	11/28/22	694.00	0.00	0.00	0.00	111.96
614	2222363004995	11/16/22 - 11/16/22	01/02/23	3,298.00	0.00	0.00	0.00	532.07
614	2223004008327	11/21/22 - 11/21/22	01/09/23	2,966.00	0.00	0.00	0.00	478.51
614	2023046081330	02/12/23 - 02/12/23	02/20/23	4,224.00	0.00	0.00	0.00	681.46
614	2023053020721	02/17/23 - 02/17/23	02/27/23	4,224.00	0.00	0.00	0.00	681.46
615	2023083090398	03/09/23 - 03/09/23	04/03/23	2,443.00	0.00	0.00	0.00	394.13
614	2223104005737	12/16/22 - 12/16/22	04/17/23	1,604.00	0.00	0.00	0.00	258.78
618	2223104005737	12/16/22 - 12/16/22	04/17/23	0.00	2,729.00	0.00	0.00	0.00
614	2223145008974	05/03/23 - 05/03/23	05/29/23	2,966.00	0.00	0.00	0.00	478.51
614	2223145008974	05/03/23 - 05/03/23	05/29/23	2,669.00	0.00	0.00	0.00	430.59
614	2023150013222	05/24/23 - 05/24/23	06/05/23	2,966.00	0.00	0.00	0.00	478.51
614	2023161020874	06/05/23 - 06/05/23	06/19/23	2,966.00	0.00	0.00	0.00	478.51
614	2023173136067	05/30/23 - 05/30/23	06/26/23	3,553.00	0.00	0.00	0.00	573.21
614	5923198000888	04/18/23 - 04/18/23	07/24/23	3,553.00	0.00	0.00	0.00	573.21
614	5923200001458	04/26/23 - 04/26/23	07/24/23	4,678.00	0.00	0.00	0.00	754.71
614	5923207000073	05/10/23 - 05/10/23	07/31/23	4,224.00	0.00	0.00	0.00	681.46
614	5923221000727	06/14/23 - 06/14/23	08/14/23	1,604.00	0.00	0.00	0.00	258.78
614	2023269075976	03/01/23 - 03/01/23	10/02/23	2,669.00	0.00	0.00	0.00	774.59
614	2223282000936	06/15/23 - 06/15/23	10/16/23	1,136.00	0.00	0.00	0.00	329.69
615	2224158002048	06/07/23 - 06/07/23	06/10/24	2,443.00	0.00	0.00	2,657.29	57.19
TOTAL				54,880.00	7,615.00	0.00	2,657.29	9,007.33

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	214,126.30	ADJUSTMENTS	0.00
COVERED CHARGES	117,443.00	CONTRACTUAL ALLOW	97,053.32
NON-COVERD CHARGES	96,683.30	TOTAL MEDICAID LIAB	20,389.68
		LESS: COB	20,389.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 50

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,212.20	0.00
MED/SURG SUPPLY	9,677.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,595.00	548.00
CT SCAN	3,670.00	14,269.00
PHYSICAL THERAPY	387.00	172.00
EKG/ECG	807.00	0.00
IV THERAPY	12,241.00	0.00
OPERATING ROOM	0.00	16,770.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	798.00	0.00
ANESTHESIA	7,529.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	52,944.00	263.00
RECOVERY ROOM	4,062.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	809.00	134.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,160.00	5,090.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	231.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,329.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,438.00	908.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,553.05	920.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	57,609.10
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	117,443.00	96,683.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,443.00	96,683.30

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	579,932.99	ADJUSTMENTS	1,476.86
COVERED CHARGES	536,088.09	CONTRACTUAL ALLOW	514,606.49
NON-COVERD CHARGES	43,844.90	TOTAL MEDICAID LIAB	21,481.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,481.60

TOTAL NUMBER OF CLAIMS 320

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	988.79	289.45
MED/SURG SUPPLY	0.00	56.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,229.00	1,696.00
CT SCAN	49,711.00	30,830.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,122.00	421.00
IV THERAPY	36,998.00	734.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	776.00	0.00
ANESTHESIA	426.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	333,810.00	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	134.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,066.00	4,882.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,276.00	1,254.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,219.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	41,251.00	2,921.00
MRI SERVICES	3,200.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,881.30	279.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	536,088.09	43,844.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	536,088.09	43,844.90

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,586.85	ADJUSTMENTS	0.00
COVERED CHARGES	6,565.85	CONTRACTUAL ALLOW	6,297.33
NON-COVERD CHARGES	21.00	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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

ST MARY'S HOSPITAL
1230 BAXTER ST
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	360.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,154.00	21.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	208.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,810.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,565.85	21.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,565.85	21.00

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,105,602.92	ADJUSTMENTS	55,648.01
COVERED CHARGES	2,635,779.09	CONTRACTUAL ALLOW	2,362,687.91
NON-COVERD CHARGES	469,823.83	TOTAL MEDICAID LIAB	273,091.18
		LESS: COB	1,871.63
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	271,219.55

TOTAL NUMBER OF CLAIMS 54

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,709.59	228.05
MED/SURG SUPPLY	161,123.57	8,637.34
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,918.00	0.00
CT SCAN	5,800.00	4,451.00
PHYSICAL THERAPY	0.00	1,837.00
EKG/ECG	0.00	0.00
IV THERAPY	23,687.00	3,248.00
OPERATING ROOM	967,997.64	115,776.36
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,320.00	474.00
ANESTHESIA	180,660.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,134.00	0.00
RECOVERY ROOM	184,558.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	569.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	20,605.00	0.00
OTHER IMAGING SERVICE	318.00	1,852.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,973.00	2,543.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,863.00	1,770.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,005.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,313.00	3,558.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,215.00	367.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	956,651.21	2,453.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	56,928.08	322,059.74
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,635,779.09	469,823.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,635,779.09	469,823.83

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,747.00	ADJUSTMENTS	0.00
COVERED CHARGES	27,347.00	CONTRACTUAL ALLOW	22,274.25
NON-COVERD CHARGES	16,400.00	TOTAL MEDICAID LIAB	5,072.75
		LESS: COB	5,072.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,485.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	862.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	16,400.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,347.00	16,400.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,347.00	16,400.00

** END OF REPORT **

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,869,169.22	ADJUSTMENTS	0.00
COVERED CHARGES	1,786,508.96	CONTRACTUAL ALLOW	1,145,969.96
NON-COVERD CHARGES	82,660.26	TOTAL MEDICAID LIAB	640,539.00
		LESS: COB	7,658.93
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	632,880.07

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	282	0	265,693.32	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	282	0	265,693.32	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	36	0	82,715.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	36	0	82,715.00	0.00
TOTAL ACCOMODATIONS	318	0	348,408.32	0.00

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,653.47	2,967.50
MED/SURG SUPPLY	287,048.32	10,164.41
LABORATORY-GENERAL	168,697.48	1,299.58
RADIOLOGY-DIAGNOSTIC	19,592.64	0.00
CT SCAN	99,625.21	0.00
PHYSICAL THERAPY	37,793.14	0.00
EKG/ECG	15,651.80	0.00
IV THERAPY	54,355.09	192.50
OPERATING ROOM	34,296.94	59,057.85
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	227,226.01	0.00
ANESTHESIA	24,650.87	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	123,742.27	0.00
RECOVERY ROOM	11,550.37	0.00
LABORATORY PATHOLOGIC	1,967.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	38,679.54	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	928.50
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 SERVICE	2,174.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,451.77	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,346.50	2,792.73
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,099.54	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	26,032.64	4,866.95

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,250.90	353.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,850.75	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	88,637.33	37.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,580.11	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,438,100.64	82,660.26
TOTAL ACCOMODATIONS	348,408.32	0.00
TOTAL CHARGES	1,786,508.96	82,660.26

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,517,003.25	ADJUSTMENTS	36,250.38
COVERED CHARGES	2,083,928.52	CONTRACTUAL ALLOW	1,459,608.71
NON-COVERD CHARGES	433,074.73	TOTAL MEDICAID LIAB	624,319.81
		LESS: COB	398.31
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	623,921.50
		ALL OTHER	575,703.79
		FEE SCHEDULE-LAB	44,278.26
		INJECTABLE DRUGS	3,939.45

TOTAL NUMBER OF CLAIMS 1,250

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,893.96	30,493.93
MED/SURG SUPPLY	123,952.62	19,906.31
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,148.87	14,955.20
CT SCAN	244,377.28	88,060.80
PHYSICAL THERAPY	6,347.78	8,047.06
EKG/ECG	41,746.25	17,683.35
IV THERAPY	181,224.35	4,857.48
OPERATING ROOM	54,094.84	104,942.97
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33,370.83	21,001.67
ANESTHESIA	32,411.86	0.00
GI SERVICES	3,702.85	8,640.13
EMERGENCY ROOM	548,649.07	6,777.09
RECOVERY ROOM	24,105.12	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,722.91	9,856.52
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	24,740.85	292.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	40,058.89	6,196.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,156.20	211.23
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,923.50	13,622.44
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,330.06	2,726.92
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	287,937.48	17,588.34

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	18,391.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	235,544.22	22,287.06
MRI SERVICES	38,706.26	1,662.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36,240.17	10,492.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,065.00	22,772.75
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	85.50	0.00

TOTAL ANCILLARY	2,083,928.52	433,074.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,083,928.52	433,074.73

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023074045707	02/22/23 - 02/22/23	03/20/23	85.50	0.00	0.00	0.00	20.52
TOTAL				85.50	0.00	0.00	0.00	20.52

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,874.26	ADJUSTMENTS	0.00
COVERED CHARGES	5,583.54	CONTRACTUAL ALLOW	3,640.37
NON-COVERD CHARGES	290.72	TOTAL MEDICAID LIAB	1,943.17
		LESS: COB	1,943.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33.98	32.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	397.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	452.52	258.22
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	302.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,931.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	146.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,583.54	290.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,583.54	290.72

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	199,921.93	ADJUSTMENTS	469.92
COVERED CHARGES	180,154.54	CONTRACTUAL ALLOW	168,719.82
NON-COVERD CHARGES	19,767.39	TOTAL MEDICAID LIAB	11,434.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	11,434.72

TOTAL NUMBER OF CLAIMS 146

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,329.02	1,456.88
MED/SURG SUPPLY	3,830.40	951.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,227.23	1,254.95
CT SCAN	12,769.13	9,662.75
PHYSICAL THERAPY	0.00	242.25
EKG/ECG	2,728.75	1,112.74
IV THERAPY	14,527.34	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,602.25	790.90
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	109,684.04	335.25
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 SERVICE	544.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,234.55	111.95

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,123.11	2,278.85
MRI SERVICES	0.00	1,479.85
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,553.87	89.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	180,154.54	19,767.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,154.54	19,767.39

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	941.38	ADJUSTMENTS	0.00
COVERED CHARGES	933.13	CONTRACTUAL ALLOW	854.81
NON-COVERD CHARGES	8.25	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	8.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83.13	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	850.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	933.13	8.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	933.13	8.25

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	370,063.96	ADJUSTMENTS	10,611.50
COVERED CHARGES	340,762.67	CONTRACTUAL ALLOW	293,010.60
NON-COVERD CHARGES	29,301.29	TOTAL MEDICAID LIAB	47,752.07
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	47,752.07

TOTAL NUMBER OF CLAIMS 9

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,591.56	2,561.61
MED/SURG SUPPLY	53,405.66	108.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	667.92	321.00
CT SCAN	1,569.00	1,425.25
PHYSICAL THERAPY	0.00	605.89
EKG/ECG	387.46	387.46
IV THERAPY	11,682.00	1,358.00
OPERATING ROOM	154,517.32	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	781.15	0.00
ANESTHESIA	16,217.69	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,347.50	0.00
RECOVERY ROOM	13,780.66	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	732.68
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	294.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,012.67	139.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,658.52	247.34
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,731.56	1,362.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,070.00	19,757.78
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	342.00	0.00

TOTAL ANCILLARY	340,762.67	29,301.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	340,762.67	29,301.29

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023118078752	03/10/23 - 03/10/23	05/01/23	85.50	0.00	0.00	0.00	20.52
780	2023118078752	03/15/23 - 03/15/23	05/01/23	85.50	0.00	0.00	0.00	20.52
780	2023118078752	03/22/23 - 03/22/23	05/01/23	85.50	0.00	0.00	0.00	20.52
780	2023118078752	03/03/23 - 03/03/23	05/01/23	85.50	0.00	0.00	0.00	20.52
TOTAL				342.00	0.00	0.00	0.00	82.08

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,310.40	ADJUSTMENTS	0.00
COVERED CHARGES	78,310.40	CONTRACTUAL ALLOW	68,755.46
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,554.94
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,554.94

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	4,818.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	4,818.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	4,818.00	0.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,600.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,525.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,907.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,296.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,389.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	784.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,856.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,230.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,506.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,399.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,492.40	0.00
TOTAL ACCOMODATIONS	4,818.00	0.00
TOTAL CHARGES	78,310.40	0.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,896,076.20	ADJUSTMENTS	56,221.92
COVERED CHARGES	3,772,498.30	CONTRACTUAL ALLOW	3,303,430.92
NON-COVERD CHARGES	123,577.90	TOTAL MEDICAID LIAB	469,067.38
		LESS: COB	304.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	468,762.70
		ALL OTHER	423,727.72
		FEE SCHEDULE-LAB	42,193.59
		INJECTABLE DRUGS	2,841.39

TOTAL NUMBER OF CLAIMS 868

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,882.10	0.00
MED/SURG SUPPLY	13,331.70	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	188,255.00	1,813.00
CT SCAN	587,728.00	57,845.00
PHYSICAL THERAPY	53,800.00	2,562.00
EKG/ECG	69,776.00	1,568.00
IV THERAPY	385,905.00	13,132.00
OPERATING ROOM	3,690.00	2,017.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50,382.00	628.00
ANESTHESIA	1,453.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,618,512.00	7,144.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,609.00	4,451.00
SPEECH PATHOLOGY	626.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	805.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,062.00	3,103.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,619.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,600.00	14,560.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,388.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	660,340.00	4,777.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	39,539.50	9,172.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,772,498.30	123,577.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,772,498.30	123,577.90

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,359.80	ADJUSTMENTS	0.00
COVERED CHARGES	58,567.80	CONTRACTUAL ALLOW	50,955.61
NON-COVERD CHARGES	6,792.00	TOTAL MEDICAID LIAB	7,612.19
		LESS: COB	7,612.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,102.40	330.00
MED/SURG SUPPLY	46.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	678.00	0.00
CT SCAN	11,513.00	3,829.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,352.00	0.00
IV THERAPY	4,345.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	754.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,212.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	825.00	1,383.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,040.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,494.00	1,250.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	206.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	58,567.80	6,792.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,567.80	6,792.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	124,685.50	ADJUSTMENTS	70.00
COVERED CHARGES	120,856.50	CONTRACTUAL ALLOW	117,286.50
NON-COVERD CHARGES	3,829.00	TOTAL MEDICAID LIAB	3,570.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,570.00

TOTAL NUMBER OF CLAIMS 51

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,256.20	0.00
MED/SURG SUPPLY	185.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,087.00	0.00
CT SCAN	14,731.00	3,829.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,568.00	0.00
IV THERAPY	5,894.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	80,982.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,681.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	472.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	120,856.50	3,829.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	120,856.50	3,829.00

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,076.40	ADJUSTMENTS	4,599.87
COVERED CHARGES	93,920.20	CONTRACTUAL ALLOW	84,720.46
NON-COVERD CHARGES	9,156.20	TOTAL MEDICAID LIAB	9,199.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,199.74

TOTAL NUMBER OF CLAIMS 2

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,142.20	0.00
MED/SURG SUPPLY	1,331.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	17,818.00	7,389.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,352.00	0.00
IV THERAPY	11,425.00	0.00
OPERATING ROOM	1,230.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,735.00	157.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,972.00	1,230.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,229.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,686.00	380.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	93,920.20	9,156.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,920.20	9,156.20

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,468,672.40	ADJUSTMENTS	1,037,929.08
COVERED CHARGES	27,253,463.52	CONTRACTUAL ALLOW	21,404,438.09
NON-COVERD CHARGES	215,208.88	TOTAL MEDICAID LIAB	5,849,025.43
		LESS: COB	32,610.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	5,355.00
		REIMBURSEMENT	5,821,769.98

TOTAL NUMBER OF ADMISSIONS 550

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,171	0	1,961,804.00	0.00
ROUTINE NURSERY	363	0	632,381.88	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.25
TOTAL ROUTINE	1,534	0	2,594,185.88	0.25
SPECIAL CARE SERVICES				
CCU	1,390	0	3,495,167.00	0.00
ICU	267	0	1,001,415.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,657	0	4,496,582.00	0.00
TOTAL ACCOMODATIONS	3,191	0	7,090,767.88	0.25

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,791,296.62	46,010.61
MED/SURG SUPPLY	1,221,403.09	0.00
LABORATORY-GENERAL	3,502,361.00	0.00
RADIOLOGY-DIAGNOSTIC	339,302.00	0.00
CT SCAN	1,486,202.17	10,268.00
PHYSICAL THERAPY	185,154.00	0.00
EKG/ECG	247,860.00	0.00
IV THERAPY	815,459.00	0.00
OPERATING ROOM	1,653,841.80	0.00
LABOR/DELIVERY ROOM	260,522.00	0.00
RESPIRATORY SERVICES	1,322,544.00	0.00
ANESTHESIA	287,088.00	0.00
GI SERVICES	278,822.00	0.00
EMERGENCY ROOM	838,736.00	0.00
RECOVERY ROOM	72,460.00	0.00
LABORATORY PATHOLOGIC	94,973.00	0.00
RADIOLOGY THERAPEUTIC	140,859.00	0.00
OCCUPATIONAL THERAPY	40,438.00	0.00
SPEECH PATHOLOGY	59,857.60	0.00
RENAL DIALYSIS	0.00	156,153.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,313.00	1,083.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	101,360.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	584,071.00	1,694.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	175,162.03	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,162,038.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,795.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	530,856.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	145,179.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	7,756.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	185,694.17	0.02
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	561,789.11	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	46,503.05	0.00

TOTAL ANCILLARY	20,162,695.64	215,208.63
TOTAL ACCOMODATIONS	7,090,767.88	0.25
TOTAL CHARGES	27,253,463.52	215,208.88

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022260023870	09/04/22 - 09/08/22	09/26/22	3,722.00	0.00	0.00	0.00	0.00
614	2022355048519	11/21/22 - 11/22/22	12/26/22	4,066.01	0.00	0.00	0.00	0.00
614	5223039000432	09/28/22 - 10/14/22	02/13/23	4,652.00	0.00	0.00	0.00	0.00
614	2023041041717	01/24/23 - 01/29/23	02/13/23	4,066.00	0.00	0.00	0.00	0.00
614	2023165039167	06/05/23 - 06/06/23	06/19/23	8,132.02	0.00	0.00	0.00	0.00
614	2023182024339	06/13/23 - 06/21/23	07/10/23	4,066.01	0.00	0.00	0.00	0.00
614	2023196026089	06/15/23 - 07/10/23	07/24/23	4,066.00	0.00	0.00	0.00	0.00
615	2024013023444	05/17/23 - 05/19/23	01/22/24	9,452.00	0.00	0.00	0.00	0.00
615	5224185000568	06/17/23 - 06/27/23	07/08/24	4,281.01	0.00	0.00	906.85	0.00
TOTAL				46,503.05	0.00	0.00	906.85	0.00

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	294,966.75	ADJUSTMENTS	0.00
COVERED CHARGES	294,966.75	CONTRACTUAL ALLOW	238,417.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	56,549.41
		LESS: COB	56,549.41
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	18	0	30,564.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18	0	30,564.00	0.00
SPECIAL CARE SERVICES				
CCU	10	0	24,500.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	10	0	24,500.00	0.00
TOTAL ACCOMODATIONS	28	0	55,064.00	0.00

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,124.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,269.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,869.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,925.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,848.01	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	989.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,913.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,977.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	28,804.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,548.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,722.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,767.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,074.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,314.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,046.99	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,340.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,969.00	0.00			

TOTAL ANCILLARY	239,902.75	0.00
TOTAL ACCOMODATIONS	55,064.00	0.00
TOTAL CHARGES	294,966.75	0.00

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,177,864.80	ADJUSTMENTS	271,819.55
COVERED CHARGES	15,652,911.07	CONTRACTUAL ALLOW	12,681,490.55
NON-COVERD CHARGES	2,524,953.73	TOTAL MEDICAID LIAB	2,971,420.52
		LESS: COB	4,995.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,966,424.57
		ALL OTHER	2,790,731.83
		FEE SCHEDULE-LAB	140,128.14
		INJECTABLE DRUGS	35,564.60

TOTAL NUMBER OF CLAIMS 4,012

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,698.47	91,833.20
MED/SURG SUPPLY	193,149.04	52,387.91
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	496,784.00	26,630.00
CT SCAN	2,383,982.45	309,354.97
PHYSICAL THERAPY	304.00	17,240.00
EKG/ECG	249,887.00	14,904.00
IV THERAPY	993,557.00	196,407.00
OPERATING ROOM	1,699,325.00	104,174.01
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	204,270.00	13,680.00
ANESTHESIA	355,385.00	0.00
GI SERVICES	359,685.60	57,479.40
EMERGENCY ROOM	2,645,954.00	15,514.00
RECOVERY ROOM	107,872.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	360,869.00	173,319.00
OCCUPATIONAL THERAPY	0.00	3,672.00
SPEECH PATHOLOGY	1,161.00	9,117.00
RENAL DIALYSIS	0.00	4,218.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,111.00	2,945.00
PSYCHIATRIC SERVICES	283,800.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	475,878.34	80,066.09
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,206.00	7,952.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	307,863.33	134,236.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	697,720.00	170,439.00
AMBULATORY SURGERY	1,533.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	245,653.00	2,992.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	716,084.00	150,653.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	118,521.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,119.00
OTHER THERAPEUTIC SVC	1,112.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,634,456.00	132,055.00
MRI SERVICES	423,217.66	49,103.10
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	431,658.46	379,140.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	39,918.49	324,322.11
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	132,295.23	0.00

TOTAL ANCILLARY	15,652,911.07	2,524,953.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,652,911.07	2,524,953.73

TANNER MEDICAL CENTER - CARROLLTON
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PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022215053773	07/20/22 - 07/20/22	08/08/22	4,932.01	0.00	0.00	0.00	1,032.41
614	2022239024166	08/23/22 - 08/23/22	09/05/22	4,914.01	0.00	0.00	0.00	1,028.64
614	2022239024169	08/17/22 - 08/17/22	09/05/22	4,914.01	0.00	0.00	0.00	1,028.64
614	2022255010204	09/07/22 - 09/07/22	09/19/22	3,722.01	0.00	0.00	0.00	762.46
614	2222266002487	09/01/22 - 09/01/22	09/26/22	4,066.00	0.00	0.00	0.00	832.92
614	2022267026863	09/20/22 - 09/20/22	10/03/22	5,162.01	0.00	0.00	0.00	1,057.45
614	2022293055940	10/14/22 - 10/14/22	10/24/22	5,162.01	0.00	0.00	0.00	1,057.45
614	2022294045759	10/07/22 - 10/07/22	10/24/22	5,162.01	0.00	0.00	0.00	1,057.45
614	2022297006568	10/19/22 - 10/19/22	10/31/22	4,066.00	0.00	0.00	0.00	832.92
614	2022340035320	12/02/22 - 12/02/22	12/12/22	3,722.01	0.00	0.00	0.00	762.46
614	2023034085971	01/30/23 - 01/30/23	02/06/23	3,876.01	0.00	0.00	0.00	794.01
614	2023034087654	01/19/23 - 01/19/23	02/06/23	5,128.01	0.00	0.00	0.00	1,050.49
614	2023037034092	01/16/23 - 01/16/23	02/13/23	4,066.01	0.00	0.00	0.00	832.94
614	2023037037291	01/06/23 - 01/06/23	02/13/23	5,672.01	0.00	0.00	0.00	1,161.93
614	2023091034214	03/27/23 - 03/27/23	04/10/23	5,652.02	0.00	0.00	0.00	1,157.82
614	2023091034214	03/27/23 - 03/27/23	04/10/23	5,743.00	0.00	0.00	0.00	1,176.46
614	2023103041777	04/04/23 - 04/04/23	04/17/23	5,652.01	0.00	0.00	0.00	1,157.82
614	2023105025624	04/11/23 - 04/11/23	04/24/23	5,652.01	0.00	0.00	0.00	1,157.82
615	2023122040221	04/25/23 - 04/25/23	05/08/23	4,726.01	0.00	0.00	0.00	968.13
614	2023123062293	04/27/23 - 04/27/23	05/08/23	5,672.01	0.00	0.00	0.00	1,161.93
614	2023139069536	05/15/23 - 05/15/23	05/22/23	5,743.01	0.00	0.00	0.00	1,176.47
614	2023142016482	05/18/23 - 05/18/23	05/29/23	5,672.01	0.00	0.00	0.00	1,161.93
614	2023152053084	05/25/23 - 05/25/23	06/05/23	5,652.01	0.00	0.00	0.00	1,157.82
614	2023154015716	05/30/23 - 05/30/23	06/12/23	4,066.00	0.00	0.00	0.00	832.92
614	5923221001253	05/25/23 - 05/25/23	08/14/23	4,281.01	0.00	0.00	0.00	876.97
614	2024256067385	12/07/22 - 12/07/22	09/16/24	5,154.01	0.00	0.00	888.71	618.40
614	2024256067385	12/07/22 - 12/07/22	09/16/24	4,066.00	0.00	0.00	888.71	487.86
TOTAL				132,295.23	0.00	0.00	1,777.42	26,384.52

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	414,799.58	ADJUSTMENTS	0.00
COVERED CHARGES	319,879.01	CONTRACTUAL ALLOW	260,767.25
NON-COVERD CHARGES	94,920.57	TOTAL MEDICAID LIAB	59,111.76
		LESS: COB	59,111.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 91

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,076.63	2,927.30
MED/SURG SUPPLY	2,788.88	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,453.00	0.00
CT SCAN	21,385.04	26,736.04
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,536.00	324.00
IV THERAPY	29,130.00	7,113.00
OPERATING ROOM	55,745.00	5,925.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,387.00	0.00
ANESTHESIA	10,203.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	71,725.00	0.00
RECOVERY ROOM	3,228.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	664.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	22,314.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,496.01	14,191.02
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,294.01	3,102.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,004.00	4,627.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,926.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,563.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	340.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,729.00	5,012.00
MRI SERVICES	0.00	6,095.01
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,895.44	8,408.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	9,455.78
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	319,879.01	94,920.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	319,879.01	94,920.57

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,364,192.81	ADJUSTMENTS	671.30
COVERED CHARGES	1,282,034.62	CONTRACTUAL ALLOW	1,250,953.43
NON-COVERD CHARGES	82,158.19	TOTAL MEDICAID LIAB	31,081.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	31,081.19

TOTAL NUMBER OF CLAIMS 463

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	719.69	4,929.92
MED/SURG SUPPLY	1,834.66	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,984.00	0.00
CT SCAN	320,316.76	37,138.06
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	17,172.00	324.00
IV THERAPY	100,185.00	15,342.00
OPERATING ROOM	12,699.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	553,962.00	2,579.00
RECOVERY ROOM	609.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,473.01	2,843.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	1,121.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,581.00	123.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,315.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	130,094.00	8,283.00
MRI SERVICES	3,931.01	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,109.49	9,475.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,282,034.62	82,158.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,282,034.62	82,158.19

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,356.27	ADJUSTMENTS	0.00
COVERED CHARGES	27,370.25	CONTRACTUAL ALLOW	26,296.17
NON-COVERD CHARGES	9,986.02	TOTAL MEDICAID LIAB	1,074.08
		LESS: COB	1,074.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 16

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	75.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,478.00	0.00
CT SCAN	0.00	4,653.01
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,620.00	0.00
IV THERAPY	1,688.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,868.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	941.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,572.00	174.00
MRI SERVICES	0.00	4,122.01
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	144.25	21.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	27,370.25	9,986.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,370.25	9,986.02

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,863,367.78	ADJUSTMENTS	45,107.11
COVERED CHARGES	3,538,394.46	CONTRACTUAL ALLOW	3,064,764.54
NON-COVERD CHARGES	1,324,973.32	TOTAL MEDICAID LIAB	473,629.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	473,629.92

TOTAL NUMBER OF CLAIMS 84

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,405.17	23,845.61
MED/SURG SUPPLY	242,710.60	62,699.27
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,268.00	2,199.00
CT SCAN	62,489.14	24,908.07
PHYSICAL THERAPY	0.00	11,767.00
EKG/ECG	19,764.00	4,860.00
IV THERAPY	326,260.00	67,078.00
OPERATING ROOM	683,007.35	67,234.65
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,533.00	0.00
ANESTHESIA	69,572.00	0.00
GI SERVICES	0.00	7,109.00
EMERGENCY ROOM	40,979.00	0.00
RECOVERY ROOM	28,425.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,186,481.00	120,466.00
OCCUPATIONAL THERAPY	0.00	1,216.00
SPEECH PATHOLOGY	0.00	3,110.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,666.00	1,909.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,639.01	7,229.01
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,604.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,016.00	13,415.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	191,396.00	173,577.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	123,016.00	49,067.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,151.00	33,191.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	187.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	119,152.00	16,725.00
MRI SERVICES	20,378.04	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	134,399.96	81,188.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	142,516.17	551,992.69
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	9,566.02	0.00

TOTAL ANCILLARY	3,538,394.46	1,324,973.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,538,394.46	1,324,973.32

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5922242001247	07/19/22 - 07/19/22	09/05/22	4,914.01	0.00	0.00	0.00	1,028.64
614	2322243000335	08/09/22 - 08/09/22	10/03/22	4,652.01	0.00	0.00	0.00	952.97
TOTAL				9,566.02	0.00	0.00	0.00	1,981.61

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,289.94	ADJUSTMENTS	0.00
COVERED CHARGES	36,183.94	CONTRACTUAL ALLOW	30,545.47
NON-COVERD CHARGES	16,106.00	TOTAL MEDICAID LIAB	5,638.47
		LESS: COB	5,638.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,411.19	279.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	406.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	583.00	FEE SCHEDULE LAB	84.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,675.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,813.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,359.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	378.75	2,180.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	13,062.50
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,183.94	16,106.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,183.94	16,106.00

** END OF REPORT **

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,721,932.59	ADJUSTMENTS	390,962.83
COVERED CHARGES	31,102,528.19	CONTRACTUAL ALLOW	25,028,357.64
NON-COVERD CHARGES	619,404.40	TOTAL MEDICAID LIAB	6,074,170.55
		LESS: COB	68,161.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,006,008.71

TOTAL NUMBER OF ADMISSIONS 731

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,712	0	2,928,640.00	0.00
ROUTINE NURSERY	248	0	324,248.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,960	0	3,252,888.50	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,119	0	2,433,496.50	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,119	0	2,433,496.50	0.00
TOTAL ACCOMODATIONS	4,079	0	5,686,385.00	0.00

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,341,966.86	1,673.49
MED/SURG SUPPLY	1,495,742.52	4,028.02
LABORATORY-GENERAL	5,302,224.79	292,743.62
RADIOLOGY-DIAGNOSTIC	825,434.28	27,920.71
CT SCAN	2,020,783.38	66,475.58
PHYSICAL THERAPY	208,049.95	12,080.68
EKG/ECG	233,524.42	5,615.08
IV THERAPY	88,673.36	37,082.31
OPERATING ROOM	860,717.19	1,990.00
LABOR/DELIVERY ROOM	232,125.67	0.00
RESPIRATORY SERVICES	1,011,607.24	0.00
ANESTHESIA	241,795.90	0.00
GI SERVICES	105,534.26	0.00
EMERGENCY ROOM	1,037,578.44	0.00
RECOVERY ROOM	90,668.34	0.00
LABORATORY PATHOLOGIC	50,050.88	44.00
RADIOLOGY THERAPEUTIC	1,503.00	0.00
OCCUPATIONAL THERAPY	68,035.05	3,859.65
SPEECH PATHOLOGY	57,325.07	3,603.72
RENAL DIALYSIS	105,545.20	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,487.72	963.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	133,796.78	16,946.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	201,819.18	120,962.09
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	168,020.63	3,451.61
AUDIOLOGY	0.00	0.00
CARDIOLOGY	518,096.51	1,645.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,149.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,072,416.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	158,722.71	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,138.58	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	175,489.70	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,566.25
INJECTABLE DRUGS	275,273.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	308,846.11	8,277.79
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	475.80

TOTAL ANCILLARY	25,416,143.19	619,404.40
TOTAL ACCOMODATIONS	5,686,385.00	0.00
TOTAL CHARGES	31,102,528.19	619,404.40

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022308010022	10/26/22 - 10/27/22	11/07/22	0.00	41.42	0.00	0.00	0.00
780	2023009037947	12/11/22 - 12/13/22	01/16/23	0.00	35.96	0.00	0.00	0.00
780	5223057000018	10/19/22 - 10/22/22	03/06/23	0.00	41.42	0.00	0.00	0.00
780	2023167072507	06/01/23 - 06/06/23	06/26/23	0.00	43.00	0.00	0.00	0.00
780	2323187000303	05/10/23 - 05/23/23	07/10/23	0.00	43.00	0.00	2,856.65	0.00
780	2023250139261	08/15/23 - 08/26/23	09/11/23	0.00	37.00	0.00	0.00	0.00
780	2023254055706	08/01/23 - 08/29/23	09/18/23	0.00	37.00	0.00	0.00	0.00
780	2323257000277	07/07/23 - 07/12/23	09/18/23	0.00	43.00	0.00	1,704.05	0.00
780	2023269071211	08/21/23 - 09/15/23	10/02/23	0.00	37.00	0.00	0.00	0.00
780	2223313009570	08/08/23 - 08/16/23	11/13/23	0.00	37.00	0.00	0.00	0.00
780	2024032099758	04/24/23 - 05/10/23	02/05/24	0.00	43.00	0.00	0.00	0.00
780	2024075080827	08/24/23 - 08/31/23	03/25/24	0.00	37.00	0.00	0.00	0.00
TOTAL				0.00	475.80	0.00	4,560.70	0.00

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	624,580.31	ADJUSTMENTS	0.00
COVERED CHARGES	623,515.23	CONTRACTUAL ALLOW	559,163.23
NON-COVERD CHARGES	1,065.08	TOTAL MEDICAID LIAB	64,352.00
		LESS: COB	64,352.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	86	0	107,383.50	0.00
ROUTINE NURSERY	4	0	3,234.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	90	0	110,617.50	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	6	0	11,706.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6	0	11,706.00	0.00
TOTAL ACCOMODATIONS	96	0	122,323.50	0.00

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,238.48	0.00	OTHER LAB	1,865.40	0.00
MED/SURG SUPPLY	32,068.22	33.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	86,016.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,947.68	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,471.03	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	206.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,582.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	696.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,187.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,673.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,341.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,598.78	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,618.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	539.75	0.00	INJECTABLE DRUGS	1,194.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	219.81	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	235.61	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,839.10	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,185.00	1,032.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,991.78	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	413.99	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,263.22	0.00			

TOTAL ANCILLARY	501,191.73	1,065.08
TOTAL ACCOMODATIONS	122,323.50	0.00
TOTAL CHARGES	623,515.23	1,065.08

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,315,790.24	ADJUSTMENTS	724,225.46
COVERED CHARGES	25,526,551.94	CONTRACTUAL ALLOW	20,596,883.32
NON-COVERD CHARGES	3,789,238.30	TOTAL MEDICAID LIAB	4,929,668.62
		LESS: COB	46,351.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,883,316.74
		ALL OTHER	3,623,710.11
		FEE SCHEDULE-LAB	494,736.84
		INJECTABLE DRUGS	764,869.79

TOTAL NUMBER OF CLAIMS 8,236

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	921,367.04	39,811.05
MED/SURG SUPPLY	441,936.18	162,865.99
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,321,873.27	28,045.00
CT SCAN	3,200,586.89	215,388.51
PHYSICAL THERAPY	0.00	15,722.65
EKG/ECG	300,475.01	18,656.64
IV THERAPY	431,613.70	44,385.80
OPERATING ROOM	1,174,508.56	427,581.53
LABOR/DELIVERY ROOM	4,998.00	0.00
RESPIRATORY SERVICES	259,166.46	6,278.00
ANESTHESIA	374,484.75	0.00
GI SERVICES	376,136.00	41,504.00
EMERGENCY ROOM	2,006,793.77	116,785.28
RECOVERY ROOM	218,236.22	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	254,663.12	157,749.59
OCCUPATIONAL THERAPY	0.00	6,361.58
SPEECH PATHOLOGY	3,659.00	6,580.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	155,611.71	2,592.83
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	591,370.75	25,576.17
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	35,588.01	2,064.00
ONCOLOGY	24,049.78	16,472.32
NUCLEAR MEDICINE	387,899.82	21,021.45
AUDIOLOGY	0.00	0.00
CARDIOLOGY	306,677.97	209,378.08
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	28,029.05	6,802.87
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	764,329.07	235,954.55

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	887,485.51	14,452.36
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	174.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,306,719.26	269,129.66
MRI SERVICES	433,293.98	13,368.85
PROFESSIONAL FEES	0.00	41.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	1,530.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	202,072.00	92,849.50
INJECTABLE DRUGS	5,112,155.56	1,218,564.59
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	352.24	370,633.59
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	419.26	916.86

TOTAL ANCILLARY	25,526,551.94	3,789,238.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,526,551.94	3,789,238.30

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022306091878	10/24/22 - 10/24/22	11/07/22	41.42	0.00	0.00	0.00	20.52
948	2022311051854	10/10/22 - 10/10/22	11/14/22	0.00	152.81	0.00	0.00	0.00
948	2022311051854	10/12/22 - 10/12/22	11/14/22	0.00	152.81	0.00	0.00	0.00
948	2022311051854	10/19/22 - 10/19/22	11/14/22	0.00	152.81	0.00	0.00	0.00
948	2022311051854	10/24/22 - 10/24/22	11/14/22	0.00	152.81	0.00	0.00	0.00
948	2022311051854	10/26/22 - 10/26/22	11/14/22	0.00	152.81	0.00	0.00	0.00
948	2022311051854	10/31/22 - 10/31/22	11/14/22	0.00	152.81	0.00	0.00	0.00
780	5923017000123	12/14/22 - 12/14/22	01/23/23	41.42	0.00	0.00	0.00	20.52
780	2023031068503	01/04/23 - 01/04/23	02/06/23	43.00	0.00	0.00	0.00	20.52
780	2023173039433	06/07/23 - 06/07/23	06/26/23	43.00	0.00	0.00	0.00	20.52
780	2023202066701	07/14/23 - 07/14/23	07/31/23	43.00	0.00	0.00	0.00	20.52
780	2023223070293	07/18/23 - 07/18/23	08/21/23	43.00	0.00	0.00	0.00	20.52
780	2023223070293	07/19/23 - 07/19/23	08/21/23	37.00	0.00	0.00	0.00	20.52
780	2023230067060	08/11/23 - 08/11/23	08/28/23	43.00	0.00	0.00	0.00	20.52
780	2023255066300	08/31/23 - 08/31/23	09/18/23	43.00	0.00	0.00	0.00	20.52
780	2023348086997	11/22/22 - 11/22/22	12/18/23	41.42	0.00	0.00	0.00	20.52
TOTAL				419.26	916.86	0.00	0.00	205.20

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	347,876.19	ADJUSTMENTS	0.00
COVERED CHARGES	236,635.57	CONTRACTUAL ALLOW	193,385.35
NON-COVERD CHARGES	111,240.62	TOTAL MEDICAID LIAB	43,250.22
		LESS: COB	43,250.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 69

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,397.15	3,753.44
MED/SURG SUPPLY	4,312.16	829.27
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,120.08	1,112.00
CT SCAN	5,751.00	32,270.21
PHYSICAL THERAPY	0.00	333.00
EKG/ECG	3,726.16	0.00
IV THERAPY	6,279.51	360.72
OPERATING ROOM	8,615.50	26,010.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	500.00	0.00
ANESTHESIA	8,687.00	0.00
GI SERVICES	2,464.00	0.00
EMERGENCY ROOM	29,658.83	2,220.00
RECOVERY ROOM	4,221.15	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	151.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,998.69	3,444.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,047.39	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,687.00	2,914.03
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	2,937.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17,144.16	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,525.12	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	80,298.54	10,411.68
MRI SERVICES	9,126.00	3,042.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,882.13	19,757.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,844.61
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	43.00	0.00

TOTAL ANCILLARY	236,635.57	111,240.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	236,635.57	111,240.62

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023133033008	04/10/23 - 04/10/23	05/22/23	43.00	0.00	0.00	1,717.12	0.00
TOTAL				43.00	0.00	0.00	1,717.12	0.00

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	873,610.96	ADJUSTMENTS	783.20
COVERED CHARGES	818,608.00	CONTRACTUAL ALLOW	797,321.20
NON-COVERD CHARGES	55,002.96	TOTAL MEDICAID LIAB	21,286.80
		LESS: COB	3.89
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,282.91

TOTAL NUMBER OF CLAIMS 272

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,933.01	1,918.50
MED/SURG SUPPLY	6,219.20	179.41
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,092.97	165.41
CT SCAN	225,439.88	21,171.62
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,713.86	0.00
IV THERAPY	7,527.01	71.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,964.71	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220,555.02	6,899.49
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,902.47	2,811.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,402.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,054.60	2,614.60

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,660.94	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	202,269.03	4,502.96
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	3,188.75
INJECTABLE DRUGS	39,830.30	11,480.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	43.00	0.00

TOTAL ANCILLARY	818,608.00	55,002.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	818,608.00	55,002.96

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	5923227000087	07/23/23 - 07/23/23	08/21/23	43.00	0.00	0.00	0.00	0.00
TOTAL				43.00	0.00	0.00	0.00	0.00

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,571.37	ADJUSTMENTS	0.00
COVERED CHARGES	1,968.78	CONTRACTUAL ALLOW	1,890.46
NON-COVERD CHARGES	5,602.59	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	310.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,602.59	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	764.44	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	794.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,968.78	5,602.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,968.78	5,602.59

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,510,654.49	ADJUSTMENTS	312,741.75
COVERED CHARGES	9,040,139.38	CONTRACTUAL ALLOW	7,974,960.13
NON-COVERD CHARGES	470,515.11	TOTAL MEDICAID LIAB	1,065,179.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,065,179.25

TOTAL NUMBER OF CLAIMS 201

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,376.56	3,399.00
MED/SURG SUPPLY	75,781.73	18,073.32
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,475.24	4,154.00
CT SCAN	44,497.43	2,835.00
PHYSICAL THERAPY	0.00	1,698.75
EKG/ECG	1,595.08	2,673.54
IV THERAPY	86,540.22	4,775.58
OPERATING ROOM	311,301.71	7,695.92
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,297.42	1,260.00
ANESTHESIA	61,329.45	0.00
GI SERVICES	25,598.00	0.00
EMERGENCY ROOM	12,304.36	11,210.28
RECOVERY ROOM	28,027.61	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	165,943.08	1,708.00
OCCUPATIONAL THERAPY	0.00	737.36
SPEECH PATHOLOGY	0.00	674.83
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,310.00	454.21
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,617.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	2,814.24	2,835.16
NUCLEAR MEDICINE	14,212.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	50,489.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	1,798.35
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	196,766.98	11,570.93

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,978.68	3,071.44
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	210.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	93,846.83	12,658.85
MRI SERVICES	10,326.85	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,712,709.91	145,923.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	231,096.88
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,040,139.38	470,515.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,040,139.38	470,515.11

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,107.55	ADJUSTMENTS	0.00
COVERED CHARGES	23,595.26	CONTRACTUAL ALLOW	18,305.51
NON-COVERD CHARGES	15,512.29	TOTAL MEDICAID LIAB	5,289.75
		LESS: COB	5,289.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

TIFT REGIONAL MEDICAL CENTER
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,685.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,290.00	242.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,812.00	1,830.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,535.33	9,070.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,147.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,475.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,304.87	4,369.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,346.00	0.00			

TOTAL ANCILLARY	23,595.26	15,512.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,595.26	15,512.29

** END OF REPORT **

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	721,828.55	ADJUSTMENTS	1,684.92
COVERED CHARGES	629,723.55	CONTRACTUAL ALLOW	386,796.55
NON-COVERD CHARGES	92,105.00	TOTAL MEDICAID LIAB	242,927.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,000.00
		REIMBURSEMENT	246,927.00

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	97	0	94,565.00	0.00
ROUTINE NURSERY	17	0	12,125.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	114	0	106,690.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	11,700.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	11,700.00	0.00
TOTAL ACCOMODATIONS	123	0	118,390.00	0.00

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,211.02	40,475.00
MED/SURG SUPPLY	15,127.82	0.00
LABORATORY-GENERAL	103,208.00	0.00
RADIOLOGY-DIAGNOSTIC	8,536.00	0.00
CT SCAN	21,231.00	48,216.00
PHYSICAL THERAPY	3,900.00	0.00
EKG/ECG	8,050.00	0.00
IV THERAPY	4,366.00	0.00
OPERATING ROOM	67,878.00	264.00
LABOR/DELIVERY ROOM	14,703.00	0.00
RESPIRATORY SERVICES	56,684.00	0.00
ANESTHESIA	7,454.00	0.00
GI SERVICES	1,232.00	0.00
EMERGENCY ROOM	55,374.00	0.00
RECOVERY ROOM	2,258.00	0.00
LABORATORY PATHOLOGIC	863.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,954.00	0.00
SPEECH PATHOLOGY	207.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,224.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,324.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	110.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,192.00	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/OBSERV. RM	11,303.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,780.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	179.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,160.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	1,890.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,098.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,385.66	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	100.00

TOTAL ANCILLARY	511,333.55	92,105.00
TOTAL ACCOMODATIONS	118,390.00	0.00
TOTAL CHARGES	629,723.55	92,105.00

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022181089970	06/20/22 - 06/21/22	07/04/22	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	100.00	0.00	0.00	0.00

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER 000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,180,353.58	ADJUSTMENTS	115,746.76
COVERED CHARGES	1,901,238.95	CONTRACTUAL ALLOW	1,440,833.35
NON-COVERD CHARGES	279,114.63	TOTAL MEDICAID LIAB	460,405.60
		LESS: COB	97.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	460,307.79
		ALL OTHER	383,827.59
		FEE SCHEDULE-LAB	49,709.53
		INJECTABLE DRUGS	26,770.67

TOTAL NUMBER OF CLAIMS 1,202

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,353.00	17,231.00
MED/SURG SUPPLY	26,366.15	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,995.00	12,044.00
CT SCAN	301,671.08	57,150.00
PHYSICAL THERAPY	12,395.00	5,090.00
EKG/ECG	27,370.00	2,300.00
IV THERAPY	162,369.00	13,749.00
OPERATING ROOM	114,004.01	49,961.99
LABOR/DELIVERY ROOM	494.00	0.00
RESPIRATORY SERVICES	28,994.00	3,256.00
ANESTHESIA	17,943.00	1,819.00
GI SERVICES	11,000.00	2,442.00
EMERGENCY ROOM	319,129.00	8,552.00
RECOVERY ROOM	7,603.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	445.00	1,666.00
SPEECH PATHOLOGY	5,785.00	4,209.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37,001.00	2,024.00
PSYCHIATRIC SERVICES	0.00	196.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	34,117.00	4,415.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,748.00	3,240.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,219.00	7,182.01
AUDIOLOGY	274.00	0.00
CARDIOLOGY	14,008.00	8,031.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	96,551.58	354.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	35,451.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	97.00
OTHER THERAPEUTIC SVC	0.00	232.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	329,362.00	39,303.00
MRI SERVICES	33,324.00	1,890.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	312.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	150,365.13	24,668.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	5,532.18
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	12,902.00	2,168.00

TOTAL ANCILLARY	1,901,238.95	279,114.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,901,238.95	279,114.63

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2222151001761	05/23/22 - 05/23/22	06/06/22	1,890.00	0.00	0.00	0.00	554.43
948	2022157048353	05/10/22 - 05/10/22	06/13/22	0.00	168.00	0.00	0.00	0.00
780	2022161027493	06/01/22 - 06/01/22	06/13/22	100.00	0.00	0.00	0.00	20.52
780	2022173017448	06/12/22 - 06/12/22	06/27/22	100.00	0.00	0.00	0.00	20.52
6363	5922181001257	05/10/22 - 05/10/22	07/04/22	0.00	30.00	0.00	0.00	0.00
780	2022207079852	07/16/22 - 07/16/22	08/01/22	100.00	0.00	0.00	0.00	20.52
780	2022238073615	08/13/22 - 08/13/22	09/05/22	100.00	0.00	0.00	0.00	20.52
780	5022241951047	07/02/22 - 07/02/22	09/05/22	100.00	0.00	0.00	0.00	20.52
780	2022241049235	08/15/22 - 08/15/22	09/05/22	100.00	0.00	0.00	0.00	20.52
780	2022241049311	08/11/22 - 08/11/22	09/05/22	100.00	0.00	0.00	0.00	20.52
780	2022244096015	08/23/22 - 08/23/22	09/05/22	100.00	0.00	0.00	0.00	20.52
780	2022263073984	09/09/22 - 09/09/22	09/26/22	100.00	0.00	0.00	0.00	20.52
6636	2222266002367	07/19/22 - 07/19/22	09/26/22	0.00	80.00	0.00	0.00	0.00
780	2022273018953	09/20/22 - 09/20/22	10/03/22	100.00	0.00	0.00	0.00	20.52
780	2022292024115	09/30/22 - 09/30/22	10/24/22	100.00	0.00	0.00	0.00	20.52
780	2022311058236	07/08/22 - 07/08/22	11/14/22	100.00	0.00	0.00	0.00	20.52
780	2022311058248	07/29/22 - 07/29/22	11/14/22	100.00	0.00	0.00	0.00	20.52
780	2022311058361	10/10/22 - 10/10/22	11/14/22	100.00	0.00	0.00	0.00	20.52
780	2022313095428	10/29/22 - 10/29/22	11/14/22	100.00	0.00	0.00	0.00	20.52
780	2022326030594	11/10/22 - 11/10/22	11/28/22	100.00	0.00	0.00	0.00	20.52
780	2022334084391	11/18/22 - 11/18/22	12/05/22	100.00	0.00	0.00	0.00	20.52
780	2022339047991	11/24/22 - 11/24/22	12/12/22	100.00	0.00	0.00	0.00	20.52
780	2022347013929	12/05/22 - 12/05/22	12/19/22	100.00	0.00	0.00	0.00	20.52
780	2023007015252	11/26/22 - 11/26/22	01/16/23	100.00	0.00	0.00	0.00	20.52
780	5023017951010	05/11/22 - 05/11/22	01/23/23	100.00	0.00	0.00	0.00	20.52
780	2023018003933	01/07/23 - 01/07/23	01/23/23	100.00	0.00	0.00	0.00	20.52
614	2223031006877	09/09/22 - 09/09/22	02/06/23	1,890.00	0.00	0.00	0.00	490.36
614	2023034098393	01/27/23 - 01/27/23	02/13/23	1,890.00	0.00	0.00	0.00	490.36
614	2223055011562	11/17/22 - 11/17/22	02/27/23	1,890.00	0.00	0.00	0.00	490.36
614	2223055011562	11/17/22 - 11/17/22	02/27/23	0.00	1,890.00	0.00	0.00	0.00
780	5023060951016	12/15/22 - 12/15/22	03/06/23	100.00	0.00	0.00	0.00	20.52
780	2023066078444	02/28/23 - 02/28/23	03/13/23	100.00	0.00	0.00	0.00	20.52
780	2023073071527	02/22/23 - 02/22/23	03/20/23	100.00	0.00	0.00	97.81	14.87
780	2223076008731	09/22/22 - 09/22/22	03/20/23	200.00	0.00	0.00	0.00	20.52
780	2023083089972	03/10/23 - 03/10/23	04/03/23	100.00	0.00	0.00	0.00	20.52
780	5923108000989	03/10/23 - 03/10/23	04/24/23	100.00	0.00	0.00	0.00	20.52
614	2223136000733	11/10/22 - 11/10/22	05/22/23	2,142.00	0.00	0.00	0.00	555.74
780	5923157081205	03/19/23 - 03/19/23	06/12/23	100.00	0.00	0.00	0.00	20.52
780	5024066981001	01/19/23 - 01/19/23	03/11/24	200.00	0.00	0.00	0.00	20.52
TOTAL				12,902.00	2,168.00	0.00	97.81	3,191.20

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,503.04	ADJUSTMENTS	0.00
COVERED CHARGES	14,306.04	CONTRACTUAL ALLOW	11,102.47
NON-COVERD CHARGES	4,197.00	TOTAL MEDICAID LIAB	3,203.57
		LESS: COB	3,203.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180.00	0.00
MED/SURG SUPPLY	235.04	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,650.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	460.00	0.00
IV THERAPY	514.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,635.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	975.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	756.00	3,459.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	300.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,467.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,181.00	398.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	253.00	40.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,306.04	4,197.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,306.04	4,197.00

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,678.51	ADJUSTMENTS	156.64
COVERED CHARGES	50,636.50	CONTRACTUAL ALLOW	48,130.26
NON-COVERD CHARGES	6,042.01	TOTAL MEDICAID LIAB	2,506.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,506.24

TOTAL NUMBER OF CLAIMS 32

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	776.50	0.00
MED/SURG SUPPLY	1,352.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,987.00	694.00
CT SCAN	3,486.00	4,170.01
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,840.00	0.00
IV THERAPY	2,346.00	739.00
OPERATING ROOM	10,595.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,142.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,193.00	0.00
RECOVERY ROOM	365.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	662.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	525.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	630.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,693.00	261.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,944.00	178.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	100.00	0.00

TOTAL ANCILLARY	50,636.50	6,042.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	50,636.50	6,042.01

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2222315006966	07/22/22 - 07/22/22	11/14/22	100.00	0.00	0.00	0.00	0.00
TOTAL				100.00	0.00	0.00	0.00	0.00

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,609.55	ADJUSTMENTS	5,094.65
COVERED CHARGES	49,221.35	CONTRACTUAL ALLOW	39,032.05
NON-COVERD CHARGES	16,388.20	TOTAL MEDICAID LIAB	10,189.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,189.30

TOTAL NUMBER OF CLAIMS 2

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,209.00	220.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,534.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	195.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	674.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,155.00	1,612.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,353.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	961.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.00	1,737.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,819.20
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	49,221.35	16,388.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,221.35	16,388.20

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

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,349,231.67	ADJUSTMENTS	208,663.95
COVERED CHARGES	14,241,918.40	CONTRACTUAL ALLOW	11,108,217.19
NON-COVERD CHARGES	107,313.27	TOTAL MEDICAID LIAB	3,133,701.21
		LESS: COB	77,709.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	19,512.00
		REIMBURSEMENT	3,075,503.74

TOTAL NUMBER OF ADMISSIONS 358

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,352	0	1,964,272.00	0.00
ROUTINE NURSERY	50	0	42,600.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	17,183.00
TOTAL ROUTINE	1,402	0	2,006,872.00	17,183.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	539	0	1,454,155.00	0.00
NICU	7	0	11,333.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	546	0	1,465,488.00	0.00
TOTAL ACCOMODATIONS	1,948	0	3,472,360.00	17,183.00

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	623,838.56	0.00
MED/SURG SUPPLY	490,887.98	4,138.75
LABORATORY-GENERAL	1,378,844.00	2,763.00
RADIOLOGY-DIAGNOSTIC	279,577.00	0.00
CT SCAN	1,276,813.00	0.00
PHYSICAL THERAPY	183,906.00	0.00
EKG/ECG	194,257.00	0.00
IV THERAPY	284,009.00	0.00
OPERATING ROOM	1,548,902.00	0.00
LABOR/DELIVERY ROOM	105,783.00	0.00
RESPIRATORY SERVICES	628,900.00	0.00
ANESTHESIA	113,496.00	0.00
GI SERVICES	72,752.00	0.00
EMERGENCY ROOM	1,170,567.00	0.00
RECOVERY ROOM	227,028.00	0.00
LABORATORY PATHOLOGIC	44,272.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,829.00	0.00
SPEECH PATHOLOGY	11,717.00	0.00
RENAL DIALYSIS	89,685.00	15,988.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,908.05	75.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	57,642.00	0.00
OTHER IMAGING SERVICE	35,893.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	57,323.00	55,694.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,731.00	4,731.00
AUDIOLOGY	9,579.02	1,696.52
CARDIOLOGY	413,765.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,744.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	41,258.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	19,765.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	354.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	353,662.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,180.00
INJECTABLE DRUGS	556,085.26	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	448,785.53	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	3,864.00

TOTAL ANCILLARY	10,769,558.40	90,130.27
TOTAL ACCOMODATIONS	3,472,360.00	17,183.00
TOTAL CHARGES	14,241,918.40	107,313.27

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023059054818	02/20/23 - 02/22/23	03/06/23	0.00	207.00	0.00	0.00	0.00
780	2023067067404	02/18/23 - 03/02/23	03/13/23	0.00	138.00	0.00	0.00	0.00
780	2023072032243	03/04/23 - 03/05/23	03/20/23	0.00	138.00	0.00	0.00	0.00
780	2023088067132	03/22/23 - 03/23/23	04/03/23	0.00	138.00	0.00	0.00	0.00
780	2023093021836	03/26/23 - 03/28/23	04/10/23	0.00	207.00	0.00	0.00	0.00
780	2023124094706	04/26/23 - 04/27/23	05/08/23	0.00	138.00	0.00	0.00	0.00
780	2023129058155	04/28/23 - 05/03/23	05/15/23	0.00	345.00	0.00	0.00	0.00
780	2023171053724	06/05/23 - 06/10/23	06/26/23	0.00	138.00	0.00	0.00	0.00
780	2023213052368	07/21/23 - 07/22/23	08/07/23	0.00	138.00	0.00	0.00	0.00
780	2023215063978	07/21/23 - 07/26/23	08/07/23	0.00	207.00	0.00	0.00	0.00
780	2023222083182	07/30/23 - 08/01/23	08/14/23	0.00	207.00	0.00	0.00	0.00
780	2023233030563	08/15/23 - 08/16/23	08/28/23	0.00	207.00	0.00	0.00	0.00
780	2023240023561	08/14/23 - 08/22/23	09/04/23	0.00	345.00	0.00	0.00	0.00
780	2023243053227	08/24/23 - 08/25/23	09/04/23	0.00	69.00	0.00	0.00	0.00
780	2023291064672	10/03/23 - 10/12/23	10/23/23	0.00	138.00	0.00	0.00	0.00
780	2023332024466	11/15/23 - 11/22/23	12/04/23	0.00	345.00	0.00	0.00	0.00
780	2224003009795	11/25/23 - 11/27/23	01/08/24	0.00	207.00	0.00	0.00	0.00
780	2024004083300	12/27/23 - 12/29/23	01/08/24	0.00	138.00	0.00	0.00	0.00
780	2024046036716	06/21/23 - 06/22/23	02/19/24	0.00	138.00	0.00	0.00	0.00
780	2324057000385	07/11/23 - 07/14/23	03/04/24	0.00	207.00	0.00	584.51	0.00
780	2324134000153	12/26/23 - 12/27/23	05/20/24	0.00	69.00	0.00	1,469.92	0.00
TOTAL				0.00	3,864.00	0.00	2,054.43	0.00

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,383.75	ADJUSTMENTS	0.00
COVERED CHARGES	48,343.74	CONTRACTUAL ALLOW	34,276.04
NON-COVERD CHARGES	40.01	TOTAL MEDICAID LIAB	14,067.70
		LESS: COB	14,067.70
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	13	0	20,248.00	0.00
ROUTINE NURSERY	2	0	1,704.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	21,952.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	2,447.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	2,447.00	0.00
TOTAL ACCOMODATIONS	16	0	24,399.00	0.00

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,115.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,562.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,067.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	642.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,770.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,074.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,537.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,042.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,721.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	413.00	40.01			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,944.74	40.01
TOTAL ACCOMODATIONS	24,399.00	0.00
TOTAL CHARGES	48,343.74	40.01

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,625,259.82	ADJUSTMENTS	617,464.58
COVERED CHARGES	15,034,174.19	CONTRACTUAL ALLOW	12,970,915.33
NON-COVERD CHARGES	591,085.63	TOTAL MEDICAID LIAB	2,063,258.86
		LESS: COB	1,312.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,061,946.60
		ALL OTHER	1,890,980.41
		FEE SCHEDULE-LAB	157,614.94
		INJECTABLE DRUGS	13,351.25

TOTAL NUMBER OF CLAIMS 3,501

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,283.47	1,631.65
MED/SURG SUPPLY	194,032.94	3,312.49
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	507,899.00	9,805.00
CT SCAN	2,634,271.00	101,917.00
PHYSICAL THERAPY	336,889.00	12,462.00
EKG/ECG	302,670.00	15,340.00
IV THERAPY	875,005.00	62,660.00
OPERATING ROOM	1,648,951.61	229,048.64
LABOR/DELIVERY ROOM	24,480.00	780.00
RESPIRATORY SERVICES	152,208.00	14,276.00
ANESTHESIA	128,111.00	548.00
GI SERVICES	119,737.68	7,578.32
EMERGENCY ROOM	3,643,081.00	7,770.00
RECOVERY ROOM	371,867.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	96,397.00	3,478.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,885.00	302.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	194,606.00	12,817.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,186.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	109,507.00	0.00
AUDIOLOGY	7,662.00	0.00
CARDIOLOGY	138,178.00	428.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,436.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	904,189.00	7,936.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	128,084.00	912.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,688,310.25	16,382.00
MRI SERVICES	269,508.00	8,179.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	586.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	144,413.05	58,662.53
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	178,808.19	14,791.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,932.00	69.00

TOTAL ANCILLARY	15,034,174.19	591,085.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,034,174.19	591,085.63

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023047072495	01/26/23 - 01/26/23	02/20/23	69.00	0.00	0.00	0.00	20.52
780	5923060000131	01/17/23 - 01/17/23	03/06/23	69.00	0.00	0.00	0.00	20.52
780	5923060000131	01/18/23 - 01/18/23	03/06/23	69.00	0.00	0.00	0.00	20.52
780	5923060000665	02/01/23 - 02/01/23	03/06/23	69.00	0.00	0.00	0.00	20.52
780	2023060071303	02/22/23 - 02/22/23	03/06/23	69.00	0.00	0.00	0.00	20.52
780	2023115053247	04/15/23 - 04/15/23	05/01/23	69.00	0.00	0.00	0.00	20.52
780	2023151052382	05/23/23 - 05/23/23	06/05/23	69.00	0.00	0.00	0.00	20.52
780	5023174951027	05/04/23 - 05/04/23	07/03/23	69.00	0.00	0.00	0.00	20.52
780	5923181001005	05/27/23 - 05/27/23	07/03/23	69.00	0.00	0.00	0.00	20.52
780	5923201000973	07/12/23 - 07/12/23	07/24/23	69.00	0.00	0.00	0.00	20.52
780	5923201000973	07/13/23 - 07/13/23	07/24/23	69.00	0.00	0.00	0.00	20.52
780	2023215096994	07/25/23 - 07/25/23	08/07/23	69.00	0.00	0.00	0.00	20.52
780	5923260000072	08/10/23 - 08/10/23	09/25/23	69.00	0.00	0.00	0.00	20.52
780	2023291064691	10/09/23 - 10/09/23	10/23/23	69.00	0.00	0.00	0.00	20.52
780	2023291064691	10/10/23 - 10/10/23	10/23/23	69.00	0.00	0.00	0.00	20.52
780	2023291064691	10/11/23 - 10/11/23	10/23/23	69.00	0.00	0.00	0.00	20.52
780	2023291064691	10/12/23 - 10/12/23	10/23/23	69.00	0.00	0.00	0.00	20.52
780	5923302000070	10/02/23 - 10/02/23	11/06/23	69.00	0.00	0.00	0.00	20.52
780	5923302000070	10/02/23 - 10/02/23	11/06/23	0.00	69.00	0.00	0.00	0.00
780	5923302000070	10/03/23 - 10/03/23	11/06/23	69.00	0.00	0.00	0.00	20.52
780	5923302000070	10/04/23 - 10/04/23	11/06/23	69.00	0.00	0.00	0.00	20.52
780	5923302000070	10/05/23 - 10/05/23	11/06/23	69.00	0.00	0.00	0.00	20.52
780	2023326082516	11/15/23 - 11/15/23	11/27/23	69.00	0.00	0.00	0.00	20.52
780	2023326082516	11/16/23 - 11/16/23	11/27/23	69.00	0.00	0.00	0.00	20.52
780	5923330000015	08/25/23 - 08/25/23	12/04/23	69.00	0.00	0.00	0.00	20.52
780	5923362001634	11/04/23 - 11/04/23	01/01/24	69.00	0.00	0.00	0.00	20.52
780	5923362001634	11/05/23 - 11/05/23	01/01/24	69.00	0.00	0.00	0.00	20.52
780	5923362001634	11/06/23 - 11/06/23	01/01/24	69.00	0.00	0.00	0.00	20.52
780	5924002001059	11/22/23 - 11/22/23	01/08/24	69.00	0.00	0.00	0.00	20.52
TOTAL				1,932.00	69.00	0.00	0.00	574.56

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	296,322.74	ADJUSTMENTS	0.00
COVERED CHARGES	220,258.41	CONTRACTUAL ALLOW	190,462.72
NON-COVERD CHARGES	76,064.33	TOTAL MEDICAID LIAB	29,795.69
		LESS: COB	29,795.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 46

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,231.24	776.75
MED/SURG SUPPLY	449.00	268.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,359.00	0.00
CT SCAN	17,257.00	41,532.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,130.00	590.00
IV THERAPY	37,744.00	2,195.00
OPERATING ROOM	21,079.67	4,793.33
LABOR/DELIVERY ROOM	5,988.00	0.00
RESPIRATORY SERVICES	750.00	0.00
ANESTHESIA	1,647.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,861.00	0.00
RECOVERY ROOM	7,918.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,970.00	1,136.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	2,942.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,721.00	15,434.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,748.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,954.00	1,179.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,451.50	5,218.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	220,258.41	76,064.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	220,258.41	76,064.33

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	475,913.80	ADJUSTMENTS	1,253.12
COVERED CHARGES	473,225.56	CONTRACTUAL ALLOW	461,320.92
NON-COVERD CHARGES	2,688.24	TOTAL MEDICAID LIAB	11,904.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	11,904.64

TOTAL NUMBER OF CLAIMS 152

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,177.95	149.00
MED/SURG SUPPLY	441.11	497.84
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,410.00	0.00
CT SCAN	88,905.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,620.00	0.00
IV THERAPY	30,057.00	1,240.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	616.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	264,615.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,348.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,182.00	578.00
MRI SERVICES	10,041.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,812.50	223.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	473,225.56	2,688.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	473,225.56	2,688.24

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,628.08	ADJUSTMENTS	0.00
COVERED CHARGES	45,663.50	CONTRACTUAL ALLOW	44,723.66
NON-COVERD CHARGES	13,964.58	TOTAL MEDICAID LIAB	939.84
		LESS: COB	939.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	0.00
MED/SURG SUPPLY	0.00	36.78
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,796.00	459.00
CT SCAN	13,672.00	13,385.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	590.00	0.00
IV THERAPY	2,176.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,340.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,887.00	72.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	184.50	11.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	45,663.50	13,964.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,663.50	13,964.58

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,064,602.53	ADJUSTMENTS	72,453.21
COVERED CHARGES	1,033,471.89	CONTRACTUAL ALLOW	939,054.03
NON-COVERD CHARGES	31,130.64	TOTAL MEDICAID LIAB	94,417.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	94,417.86

TOTAL NUMBER OF CLAIMS 17

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,871.75	31.20
MED/SURG SUPPLY	53,833.26	296.77
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,729.00	4,593.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,150.00
EKG/ECG	5,310.00	0.00
IV THERAPY	786.00	454.00
OPERATING ROOM	421,751.67	15,311.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	26,159.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,000.00	0.00
RECOVERY ROOM	48,428.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	36,011.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	542.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,793.33	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,585.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,614.84	9,294.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	414,057.04	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,033,471.89	31,130.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,033,471.89	31,130.64

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

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,847,071.20	ADJUSTMENTS	1,170,467.32
COVERED CHARGES	8,700,877.87	CONTRACTUAL ALLOW	7,182,979.29
NON-COVERD CHARGES	146,193.33	TOTAL MEDICAID LIAB	1,517,898.58
		LESS: COB	8,387.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,509,511.56

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	240	0	578,160.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	240	0	578,160.00	0.00
SPECIAL CARE SERVICES				
CCU	257	0	1,817,504.00	0.00
ICU	209	0	1,529,086.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	466	0	3,346,590.00	0.00
TOTAL ACCOMODATIONS	706	0	3,924,750.00	0.00

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	839,651.50	59,366.00
MED/SURG SUPPLY	172,895.37	5,353.33
LABORATORY-GENERAL	523,348.00	28,304.00
RADIOLOGY-DIAGNOSTIC	63,592.00	648.00
CT SCAN	83,301.00	0.00
PHYSICAL THERAPY	111,076.00	7,311.00
EKG/ECG	17,248.00	0.00
IV THERAPY	161.00	0.00
OPERATING ROOM	180,031.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,226,843.00	0.00
ANESTHESIA	13,891.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,051.00	0.00
LABORATORY PATHOLOGIC	4,275.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	105,393.00	2,387.00
SPEECH PATHOLOGY	48,978.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	84.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,430.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	39,513.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,691.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,810.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	150,914.00	42,824.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	155,550.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	15,401.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,776,127.87	146,193.33
TOTAL ACCOMODATIONS	3,924,750.00	0.00
TOTAL CHARGES	8,700,877.87	146,193.33

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,290,709.98	ADJUSTMENTS	95,959.85
COVERED CHARGES	9,642,586.03	CONTRACTUAL ALLOW	7,968,988.55
NON-COVERD CHARGES	648,123.95	TOTAL MEDICAID LIAB	1,673,597.48
		LESS: COB	12,524.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,661,073.35
		ALL OTHER	1,600,913.48
		FEE SCHEDULE-LAB	993.09
		INJECTABLE DRUGS	59,166.78

TOTAL NUMBER OF CLAIMS 2,625

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,696.30	0.00
MED/SURG SUPPLY	49,555.64	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,247.00	0.00
CT SCAN	169,867.00	11,606.00
PHYSICAL THERAPY	6,729,963.00	111,634.00
EKG/ECG	1,506.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	902,112.95	221,650.05
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	436,299.00	0.00
GI SERVICES	22,288.00	11,144.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	215,218.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	41,820.00	4,457.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	65,838.00	2,948.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,796.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,502.00	2,262.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	209,024.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,900.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,439.00	0.00
MRI SERVICES	192,046.00	46,919.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	397,819.50	235,503.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	45,648.64	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,642,586.03	648,123.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,642,586.03	648,123.95

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	246,185.57	ADJUSTMENTS	0.00
COVERED CHARGES	162,268.17	CONTRACTUAL ALLOW	135,326.54
NON-COVERD CHARGES	83,917.40	TOTAL MEDICAID LIAB	26,941.63
		LESS: COB	26,941.63
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,065.50	0.00
MED/SURG SUPPLY	845.57	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	4,158.00	16,150.00
PHYSICAL THERAPY	7,224.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	56,688.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	29,204.00	0.00
GI SERVICES	0.00	13,816.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	14,725.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,258.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,166.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,201.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,991.10	52,693.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	162,268.17	83,917.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	162,268.17	83,917.40

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	358,203.10	ADJUSTMENTS	5,963.73
COVERED CHARGES	301,716.20	CONTRACTUAL ALLOW	265,933.82
NON-COVERD CHARGES	56,486.90	TOTAL MEDICAID LIAB	35,782.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	35,782.38

TOTAL NUMBER OF CLAIMS 6

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,897.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34,808.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,497.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	563.00	FEE SCHEDULE LAB	413.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,218.50	46,897.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,372.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,368.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,538.60	9,026.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	91,602.78	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	301,716.20	56,486.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	301,716.20	56,486.90

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,684,210.68	ADJUSTMENTS	727,329.05
COVERED CHARGES	19,515,611.20	CONTRACTUAL ALLOW	14,004,744.71
NON-COVERD CHARGES	168,599.48	TOTAL MEDICAID LIAB	5,510,866.49
		LESS: COB	14,496.49
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,890.00
		REIMBURSEMENT	5,498,260.00

TOTAL NUMBER OF ADMISSIONS 948

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,661	0	8,361,478.00	0.00
ROUTINE NURSERY	85	0	88,187.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.48
TOTAL ROUTINE	5,746	0	8,449,665.00	0.48
SPECIAL CARE SERVICES				
CCU	504	0	1,270,470.00	0.00
ICU	93	0	351,279.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	597	0	1,621,749.00	0.00
TOTAL ACCOMODATIONS	6,343	0	10,071,414.00	0.48

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,746,220.81	0.00
MED/SURG SUPPLY	507,695.53	0.00
LABORATORY-GENERAL	2,257,005.00	0.00
RADIOLOGY-DIAGNOSTIC	133,071.00	0.00
CT SCAN	759,616.16	7,701.00
PHYSICAL THERAPY	73,798.00	0.00
EKG/ECG	125,388.00	0.00
IV THERAPY	385,237.00	0.00
OPERATING ROOM	286,065.00	13,175.00
LABOR/DELIVERY ROOM	71,049.00	0.00
RESPIRATORY SERVICES	503,657.00	0.00
ANESTHESIA	70,951.00	0.00
GI SERVICES	96,156.00	0.00
EMERGENCY ROOM	687,307.00	0.00
RECOVERY ROOM	16,894.00	0.00
LABORATORY PATHOLOGIC	24,948.00	0.00
RADIOLOGY THERAPEUTIC	48,819.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	12,850.00	0.00
RENAL DIALYSIS	0.00	104,289.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,347.00	209.00
PSYCHIATRIC SERVICES	0.00	43,000.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	62,234.08	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	107,101.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	93,862.01	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	827,254.01	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,986.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	272,225.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	44,469.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,695.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	104,701.07	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	225.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	78,160.52	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	31,435.01	0.00

TOTAL ANCILLARY	9,444,197.20	168,599.00
TOTAL ACCOMODATIONS	10,071,414.00	0.48
TOTAL CHARGES	19,515,611.20	168,599.48

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023041042292	01/31/23 - 02/01/23	02/13/23	4,281.01	0.00	0.00	0.00	0.00
614	2023094020261	03/10/23 - 03/27/23	04/10/23	4,066.00	0.00	0.00	0.00	0.00
614	2023102052168	04/03/23 - 04/04/23	04/17/23	5,743.00	0.00	0.00	0.00	0.00
614	2023115043164	04/10/23 - 04/13/23	05/01/23	4,066.00	0.00	0.00	0.00	0.00
615	5223184000225	04/30/23 - 05/11/23	07/10/23	4,281.00	0.00	0.00	0.00	0.00
614	2023264053044	09/30/22 - 10/06/22	09/25/23	4,932.00	0.00	0.00	0.00	0.00
614	2023335077918	07/17/22 - 07/20/22	12/04/23	4,066.00	0.00	0.00	0.00	0.00
TOTAL				31,435.01	0.00	0.00	0.00	0.00

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	196,440.00	ADJUSTMENTS	0.00
COVERED CHARGES	196,440.00	CONTRACTUAL ALLOW	141,377.09
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	55,062.91
		LESS: COB	55,062.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	77	0	115,913.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	77	0	115,913.00	0.00
SPECIAL CARE SERVICES				
CCU	1	0	2,573.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	2,573.00	0.00
TOTAL ACCOMODATIONS	78	0	118,486.00	0.00

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,899.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,300.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,938.00	0.00	EDUCATION & TRAINING	79.00	0.00
RADIOLOGY-DIAGNOSTIC	1,265.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,658.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,712.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,267.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,800.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,739.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,341.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	641.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	506.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,963.52	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,265.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	579.00	0.00			

TOTAL ANCILLARY	77,954.00	0.00
TOTAL ACCOMODATIONS	118,486.00	0.00
TOTAL CHARGES	196,440.00	0.00

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER 000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,056,321.78	ADJUSTMENTS	490,842.61
COVERED CHARGES	18,116,578.91	CONTRACTUAL ALLOW	12,644,331.99
NON-COVERD CHARGES	3,939,742.87	TOTAL MEDICAID LIAB	5,472,246.92
		LESS: COB	4,401.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,467,845.32
		ALL OTHER	2,066,809.90
		FEE SCHEDULE-LAB	95,904.45
		INJECTABLE DRUGS	3,305,130.97

TOTAL NUMBER OF CLAIMS 3,916

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,553.72	111,370.07
MED/SURG SUPPLY	72,967.74	9,070.35
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350,812.00	4,813.00
CT SCAN	1,807,465.77	177,420.32
PHYSICAL THERAPY	1,293.00	10,919.00
EKG/ECG	133,164.00	8,424.00
IV THERAPY	1,016,548.00	161,846.00
OPERATING ROOM	364,227.00	84,613.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	77,509.00	17,517.00
ANESTHESIA	133,541.00	0.00
GI SERVICES	215,732.93	37,858.07
EMERGENCY ROOM	1,895,150.00	11,707.00
RECOVERY ROOM	33,391.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	363,534.00	53,621.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	2,155.00
RENAL DIALYSIS	0.00	10,545.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	66,571.00	30,304.00
PSYCHIATRIC SERVICES	634,875.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	154,622.00	52,273.03
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	75,648.00	84,716.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	176,094.10	58,352.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	320,784.00	47,718.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	73,924.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	292,764.00	83,830.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	73,346.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	366.00
OTHER THERAPEUTIC SVC	3,546.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,127,080.00	91,442.00
MRI SERVICES	287,590.45	31,243.05
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,238,199.64	2,707,834.24
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	14,694.41	39,832.52
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	79,951.15	9,953.02

TOTAL ANCILLARY	18,116,578.91	3,939,742.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,116,578.91	3,939,742.87

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022199008351	07/13/22 - 07/13/22	07/25/22	5,162.01	0.00	0.00	0.00	1,287.88
615	2022209059457	07/15/22 - 07/15/22	08/01/22	4,913.01	0.00	0.00	0.00	1,225.76
614	2022217063737	08/01/22 - 08/01/22	08/08/22	4,066.01	0.00	0.00	0.00	1,014.44
614	2022256039544	09/09/22 - 09/09/22	09/19/22	4,066.01	0.00	0.00	0.00	954.39
614	2222269003288	08/24/22 - 08/24/22	10/03/22	4,914.01	0.00	0.00	0.00	1,153.44
614	2022294045781	10/17/22 - 10/17/22	10/24/22	4,066.00	0.00	0.00	0.00	954.39
614	2022313050543	11/01/22 - 11/01/22	11/14/22	3,722.01	0.00	0.00	0.00	873.65
614	2023037038918	01/12/23 - 01/12/23	02/13/23	4,066.00	0.00	0.00	0.00	954.39
614	2023037033516	01/13/23 - 01/13/23	02/13/23	5,652.01	0.00	0.00	0.00	1,326.66
614	2223062014453	02/17/23 - 02/17/23	03/06/23	4,066.00	0.00	0.00	0.00	954.39
614	2023067046866	03/03/23 - 03/03/23	03/13/23	0.00	5,672.01	0.00	0.00	0.00
614	2023098012512	04/04/23 - 04/04/23	04/17/23	4,066.01	0.00	0.00	0.00	954.39
614	2023115043232	04/21/23 - 04/21/23	05/01/23	4,281.01	0.00	0.00	0.00	1,004.86
614	2023118051900	04/24/23 - 04/24/23	05/01/23	4,281.01	0.00	0.00	0.00	1,004.86
614	2023135006733	05/10/23 - 05/10/23	05/22/23	8,562.02	0.00	0.00	0.00	2,009.71
614	2023135017103	05/11/23 - 05/11/23	05/22/23	4,066.01	0.00	0.00	0.00	954.39
614	2023152057038	05/23/23 - 05/23/23	06/05/23	5,721.01	0.00	0.00	0.00	1,342.86
614	2023178037675	06/23/23 - 06/23/23	07/03/23	4,281.01	0.00	0.00	0.00	1,004.86
615	5923187000481	06/16/23 - 06/16/23	07/10/23	0.00	4,281.01	0.00	0.00	0.00
TOTAL				79,951.15	9,953.02	0.00	0.00	18,975.32

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	502,678.57	ADJUSTMENTS	0.00
COVERED CHARGES	348,239.09	CONTRACTUAL ALLOW	274,544.10
NON-COVERD CHARGES	154,439.48	TOTAL MEDICAID LIAB	73,694.99
		LESS: COB	73,694.99
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	378.00	2,754.92
MED/SURG SUPPLY	1,387.00	371.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,186.00	0.00
CT SCAN	46,001.10	22,368.07
PHYSICAL THERAPY	0.00	304.00
EKG/ECG	4,860.00	0.00
IV THERAPY	33,744.00	2,521.00
OPERATING ROOM	18,756.50	6,175.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,000.00	0.00
ANESTHESIA	7,040.00	0.00
GI SERVICES	12,791.00	2,659.00
EMERGENCY ROOM	103,566.00	0.00
RECOVERY ROOM	935.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,240.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	400.00	0.00
PSYCHIATRIC SERVICES	23,673.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,341.00	10,228.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,868.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,978.00	213.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,216.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,732.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,581.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,472.00	2,649.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,093.49	85,689.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	18,506.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	348,239.09	154,439.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	348,239.09	154,439.48

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	999,747.49	ADJUSTMENTS	469.91
COVERED CHARGES	940,999.09	CONTRACTUAL ALLOW	917,906.37
NON-COVERD CHARGES	58,748.40	TOTAL MEDICAID LIAB	23,092.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	23,092.72

TOTAL NUMBER OF CLAIMS 344

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	4,114.96
MED/SURG SUPPLY	19.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,071.00	0.00
CT SCAN	257,963.52	30,614.07
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	13,608.00	0.00
IV THERAPY	84,923.00	10,434.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,800.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	400,384.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	219.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	819.00	2,602.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	426.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,085.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	93,560.00	6,009.00
MRI SERVICES	5,300.01	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,040.56	4,755.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	940,999.09	58,748.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	940,999.09	58,748.40

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,044.84	ADJUSTMENTS	0.00
COVERED CHARGES	14,046.51	CONTRACTUAL ALLOW	13,442.34
NON-COVERD CHARGES	6,998.33	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	798.00	0.00
CT SCAN	0.00	6,802.02
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	324.00	0.00
IV THERAPY	1,008.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,278.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,467.00	116.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	171.51	80.31
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,046.51	6,998.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,046.51	6,998.33

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,565,151.10	ADJUSTMENTS	80,281.53
COVERED CHARGES	6,195,529.25	CONTRACTUAL ALLOW	5,274,595.67
NON-COVERD CHARGES	369,621.85	TOTAL MEDICAID LIAB	920,933.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	920,933.58

TOTAL NUMBER OF CLAIMS 174

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,828.61	13,603.92
MED/SURG SUPPLY	46,864.49	4,177.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,008.00	1,648.00
CT SCAN	69,910.16	0.00
PHYSICAL THERAPY	608.00	3,804.00
EKG/ECG	5,832.00	1,944.00
IV THERAPY	80,750.00	16,528.00
OPERATING ROOM	319,806.00	14,743.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,896.00	0.00
ANESTHESIA	40,672.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,778.00	0.00
RECOVERY ROOM	13,207.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	146,622.00	5,553.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,658.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,183.00	4,909.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	741.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	25,587.00	17,460.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	58,773.00	5,515.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	53,765.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,966.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	56.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	40,373.00	5,285.00
MRI SERVICES	9,231.02	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,211,127.97	161,103.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	111,634.91
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,195,529.25	369,621.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,195,529.25	369,621.85

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	122,575.27	ADJUSTMENTS	0.00
COVERED CHARGES	106,143.50	CONTRACTUAL ALLOW	90,288.47
NON-COVERD CHARGES	16,431.77	TOTAL MEDICAID LIAB	15,855.03
		LESS: COB	15,855.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	353.54	439.96	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	301.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	327.00	824.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	304.00	FEE SCHEDULE LAB	563.00	29.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	546.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,079.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,104.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,581.14	1,334.81
RADIOLOGY THERAPEUTIC	888.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	13,500.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	106,143.50	16,431.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	106,143.50	16,431.77

** END OF REPORT **

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,555,532.37	ADJUSTMENTS	13,797.39
COVERED CHARGES	4,541,624.37	CONTRACTUAL ALLOW	3,601,791.09
NON-COVERD CHARGES	13,908.00	TOTAL MEDICAID LIAB	939,833.28
		LESS: COB	37,149.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	12,000.00
		REIMBURSEMENT	914,684.06

TOTAL NUMBER OF ADMISSIONS 146

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	591	0	424,434.00	0.00
ROUTINE NURSERY	29	0	12,383.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	620	0	436,817.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	135	0	225,082.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	135	0	225,082.00	0.00
TOTAL ACCOMODATIONS	755	0	661,899.00	0.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,104,834.30	0.00
MED/SURG SUPPLY	448,477.08	0.00
LABORATORY-GENERAL	415,652.63	0.00
RADIOLOGY-DIAGNOSTIC	43,981.00	0.00
CT SCAN	180,665.00	0.00
PHYSICAL THERAPY	40,527.00	0.00
EKG/ECG	18,231.00	0.00
IV THERAPY	92,772.00	0.00
OPERATING ROOM	563,007.00	0.00
LABOR/DELIVERY ROOM	7,224.00	0.00
RESPIRATORY SERVICES	285,864.00	0.00
ANESTHESIA	68,640.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	347,127.00	0.00
RECOVERY ROOM	17,555.00	0.00
LABORATORY PATHOLOGIC	2,122.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	675.00	0.00
RENAL DIALYSIS	1,734.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,256.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,551.83	6,132.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,232.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,481.00	0.00
AMBULATORY SURGERY	4,590.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	56,255.53	7,776.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,854.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	56,704.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,798.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	9,915.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,879,725.37	13,908.00
TOTAL ACCOMODATIONS	661,899.00	0.00
TOTAL CHARGES	4,541,624.37	13,908.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,138.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,138.00	CONTRACTUAL ALLOW	1,763.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,374.95
		LESS: COB	1,374.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	2	2	1,708.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	2	1,708.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	2	1,708.00	0.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	392.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	728.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	310.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,430.00	0.00
TOTAL ACCOMODATIONS	1,708.00	0.00
TOTAL CHARGES	3,138.00	0.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,140,414.32	ADJUSTMENTS	350,941.83
COVERED CHARGES	5,096,787.22	CONTRACTUAL ALLOW	4,269,775.14
NON-COVERD CHARGES	1,043,627.10	TOTAL MEDICAID LIAB	827,012.08
		LESS: COB	4,065.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	822,947.06
		ALL OTHER	661,804.58
		FEE SCHEDULE-LAB	78,099.69
		INJECTABLE DRUGS	83,042.79

TOTAL NUMBER OF CLAIMS 1,854

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192,332.00	3,511.00
MED/SURG SUPPLY	526,557.52	567.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,254.00	3,943.00
CT SCAN	298,955.00	387,109.00
PHYSICAL THERAPY	53,045.00	11,441.00
EKG/ECG	42,348.00	3,036.00
IV THERAPY	298,319.00	111,976.00
OPERATING ROOM	633,224.50	109,316.50
LABOR/DELIVERY ROOM	4,888.00	752.00
RESPIRATORY SERVICES	10,986.00	15,724.00
ANESTHESIA	108,047.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,460,173.00	2,750.00
RECOVERY ROOM	24,870.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	69,442.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,149.00
RENAL DIALYSIS	0.00	578.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,393.00
PSYCHIATRIC SERVICES	0.00	168.00
LITHOTRIPSY	99,840.00	0.00
OTHER IMAGING SERVICE	82,860.00	22,989.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,210.06	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,593.00	25,263.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,472.00	41,368.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	260,262.20	25,469.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,101.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	489,006.77	48,196.77
MRI SERVICES	95,569.00	27,778.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	205,432.17	74,845.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	124,304.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,096,787.22	1,043,627.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,096,787.22	1,043,627.10

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	263,007.73	ADJUSTMENTS	0.00
COVERED CHARGES	113,546.73	CONTRACTUAL ALLOW	97,180.88
NON-COVERD CHARGES	149,461.00	TOTAL MEDICAID LIAB	16,365.85
		LESS: COB	16,365.85
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,018.50	0.00
MED/SURG SUPPLY	17,345.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,600.00	268.00
CT SCAN	0.00	6,738.00
PHYSICAL THERAPY	3,026.00	176.00
EKG/ECG	1,154.00	132.00
IV THERAPY	5,119.00	5,818.00
OPERATING ROOM	13,554.00	17,281.00
LABOR/DELIVERY ROOM	2,256.00	376.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,450.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,486.00	0.00
RECOVERY ROOM	1,050.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,422.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	231.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,300.00	516.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	2,100.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	150.00	5,823.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,106.32	1,561.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,509.51	108,441.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	113,546.73	149,461.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	113,546.73	149,461.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,249,380.90	ADJUSTMENTS	6,108.96
COVERED CHARGES	1,041,185.47	CONTRACTUAL ALLOW	1,007,194.59
NON-COVERD CHARGES	208,195.43	TOTAL MEDICAID LIAB	33,990.88
		LESS: COB	59.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	33,931.51

TOTAL NUMBER OF CLAIMS 434

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,636.00	1,324.00
MED/SURG SUPPLY	46,848.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,863.00	147.00
CT SCAN	76,041.00	149,935.00
PHYSICAL THERAPY	0.00	293.00
EKG/ECG	8,576.00	132.00
IV THERAPY	57,519.00	39,911.00
OPERATING ROOM	6,317.50	6,317.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,589.00	0.00
ANESTHESIA	2,783.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	639,996.00	0.00
RECOVERY ROOM	750.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	19,968.00	0.00
OTHER IMAGING SERVICE	536.00	1,332.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,682.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,326.66	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,970.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	97,272.70	6,417.00
MRI SERVICES	3,634.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,877.61	2,386.93
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,041,185.47	208,195.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,041,185.47	208,195.43

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,971.00	ADJUSTMENTS	0.00
COVERED CHARGES	34,760.00	CONTRACTUAL ALLOW	33,585.20
NON-COVERD CHARGES	7,211.00	TOTAL MEDICAID LIAB	1,174.80
		LESS: COB	1,174.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 15

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,061.00	0.00
MED/SURG SUPPLY	1,771.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	588.00	0.00
CT SCAN	5,413.00	4,185.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	264.00	132.00
IV THERAPY	1,072.00	2,056.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	376.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,540.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	268.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	543.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,431.00	306.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	701.00	264.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,760.00	7,211.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,760.00	7,211.00

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,542,339.65	ADJUSTMENTS	161,744.10
COVERED CHARGES	1,329,055.49	CONTRACTUAL ALLOW	1,097,222.28
NON-COVERD CHARGES	213,284.16	TOTAL MEDICAID LIAB	231,833.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	231,833.21

TOTAL NUMBER OF CLAIMS 43

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,633.00	0.00
MED/SURG SUPPLY	177,383.00	332.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,018.00	1,764.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	3,749.00
EKG/ECG	2,112.00	132.00
IV THERAPY	28,344.00	536.00
OPERATING ROOM	666,462.50	39,415.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,216.00	0.00
ANESTHESIA	79,810.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	13,845.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	24,849.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,159.74	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,427.72	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,979.57	3,260.92
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	223,815.96	5,516.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	158,578.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,329,055.49	213,284.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,329,055.49	213,284.16

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

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,612,107.24	ADJUSTMENTS	452,453.65
COVERED CHARGES	46,437,642.04	CONTRACTUAL ALLOW	40,572,802.79
NON-COVERD CHARGES	174,465.20	TOTAL MEDICAID LIAB	5,864,839.25
		LESS: COB	54,992.71
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,835.00
		REIMBURSEMENT	5,812,681.54

TOTAL NUMBER OF ADMISSIONS 623

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,483	0	3,572,547.00	0.00
ROUTINE NURSERY	108	0	499,566.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,591	0	4,072,113.00	0.00
SPECIAL CARE SERVICES				
CCU	971	0	6,875,752.00	0.00
ICU	480	0	3,611,004.00	0.00
NICU	8	0	90,576.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,459	0	10,577,332.00	0.00
TOTAL ACCOMODATIONS	3,050	0	14,649,445.00	0.00

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,119,915.40	0.00
MED/SURG SUPPLY	1,132,507.93	0.00
LABORATORY-GENERAL	6,298,158.73	0.00
RADIOLOGY-DIAGNOSTIC	592,949.00	0.00
CT SCAN	2,586,705.00	36,097.00
PHYSICAL THERAPY	199,606.00	0.00
EKG/ECG	696,678.00	0.00
IV THERAPY	646,497.00	0.00
OPERATING ROOM	2,842,744.67	0.00
LABOR/DELIVERY ROOM	349,571.00	0.00
RESPIRATORY SERVICES	2,649,487.00	0.00
ANESTHESIA	847,370.33	0.00
GI SERVICES	217,314.00	0.00
EMERGENCY ROOM	2,179,394.00	0.00
RECOVERY ROOM	345,748.00	0.00
LABORATORY PATHOLOGIC	107,597.00	0.00
RADIOLOGY THERAPEUTIC	7,596.00	0.00
OCCUPATIONAL THERAPY	45,219.00	0.00
SPEECH PATHOLOGY	98,683.00	0.00
RENAL DIALYSIS	0.00	130,113.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,821.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	132,251.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	729,927.00	7,090.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	166,462.60	1,165.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,212,754.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	61,279.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,598,380.05	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	346,834.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,298.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	354,640.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	209,809.33	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	31,788,197.04	174,465.20
TOTAL ACCOMODATIONS	14,649,445.00	0.00
TOTAL CHARGES	46,437,642.04	174,465.20

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	361,741.29	ADJUSTMENTS	0.00
COVERED CHARGES	361,741.29	CONTRACTUAL ALLOW	319,088.24
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	42,653.05
		LESS: COB	42,716.05
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	33,726.00	0.00
ROUTINE NURSERY	1	0	8,216.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	41,942.00	0.00
SPECIAL CARE SERVICES				
CCU	4	0	28,288.00	0.00
ICU	2	0	15,912.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6	0	44,200.00	0.00
TOTAL ACCOMODATIONS	21	0	86,142.00	0.00

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
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PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,587.60	0.00	OTHER LAB	2,525.00	0.00
MED/SURG SUPPLY	11,327.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,183.00	0.00	EDUCATION & TRAINING	390.00	0.00
RADIOLOGY-DIAGNOSTIC	3,240.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	764.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,488.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,538.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,428.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,058.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,240.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,267.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,743.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,702.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	161.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	857.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,743.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,189.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,167.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,658.76	0.00			

TOTAL ANCILLARY	275,599.29	0.00
TOTAL ACCOMODATIONS	86,142.00	0.00
TOTAL CHARGES	361,741.29	0.00

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,032,961.85	ADJUSTMENTS	166,292.41
COVERED CHARGES	26,530,094.10	CONTRACTUAL ALLOW	23,739,648.48
NON-COVERD CHARGES	1,502,867.75	TOTAL MEDICAID LIAB	2,790,445.62
		LESS: COB	10,471.90
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,779,973.72
		ALL OTHER	2,308,501.52
		FEE SCHEDULE-LAB	264,880.81
		INJECTABLE DRUGS	206,591.39

TOTAL NUMBER OF CLAIMS 5,079

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285,606.27	330.00
MED/SURG SUPPLY	353,229.52	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	807,008.00	8,421.00
CT SCAN	3,441,848.00	159,316.00
PHYSICAL THERAPY	122,517.00	3,592.00
EKG/ECG	534,904.00	7,056.00
IV THERAPY	1,095,096.00	47,574.00
OPERATING ROOM	1,472,964.86	293,356.14
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	167,416.00	21,313.00
ANESTHESIA	943,877.00	0.00
GI SERVICES	623,375.36	162,843.64
EMERGENCY ROOM	5,399,977.00	34,033.00
RECOVERY ROOM	425,506.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	196,767.00	46,352.00
OCCUPATIONAL THERAPY	32,676.00	6,341.00
SPEECH PATHOLOGY	6,992.00	5,024.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,379.20	5,162.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	509,582.10	31,473.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	103,662.00	208.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	289,894.20	9,452.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	851,501.00	72,594.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	224,575.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	603,953.31	78,712.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	306,721.00	17,919.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,573,897.50	94,104.64
MRI SERVICES	469,696.00	21,411.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,629,271.65	369,639.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	6,641.00
IMPL DEV CHARGE PATIENTS	51,201.13	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	26,530,094.10	1,502,867.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,530,094.10	1,502,867.75

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	291,811.11	ADJUSTMENTS	0.00
COVERED CHARGES	263,184.11	CONTRACTUAL ALLOW	236,340.75
NON-COVERD CHARGES	28,627.00	TOTAL MEDICAID LIAB	26,843.36
		LESS: COB	26,843.36
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 46

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,062.90	0.00
MED/SURG SUPPLY	2,622.86	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,068.00	0.00
CT SCAN	23,223.00	14,778.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,954.00	0.00
IV THERAPY	22,420.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,508.00	0.00
ANESTHESIA	6,917.00	0.00
GI SERVICES	5,572.00	5,572.00
EMERGENCY ROOM	68,218.00	0.00
RECOVERY ROOM	2,736.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,849.00	2,516.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,608.00	3,897.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,374.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,606.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	59,480.00	1,411.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,745.70	453.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,219.65	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	263,184.11	28,627.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	263,184.11	28,627.00

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	701,600.89	ADJUSTMENTS	268.52
COVERED CHARGES	672,360.49	CONTRACTUAL ALLOW	656,652.07
NON-COVERD CHARGES	29,240.40	TOTAL MEDICAID LIAB	15,708.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,708.42

TOTAL NUMBER OF CLAIMS 234

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,312.70	0.00
MED/SURG SUPPLY	12,687.99	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,382.00	0.00
CT SCAN	18,168.00	22,824.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,192.00	0.00
IV THERAPY	35,293.00	0.00
OPERATING ROOM	12,755.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,189.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	388,623.00	0.00
RECOVERY ROOM	2,490.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	322.00	161.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,258.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,624.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	118,338.00	1,656.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,725.80	4,599.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	672,360.49	29,240.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	672,360.49	29,240.40

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	24,023.90	ADJUSTMENTS	0.00
COVERED CHARGES	24,023.90	CONTRACTUAL ALLOW	23,755.38
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	354.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,046.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,719.00	0.00
EKG/ECG	784.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,190.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,282.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,023.90	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,023.90	0.00

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,001,588.76	ADJUSTMENTS	59,306.17
COVERED CHARGES	4,782,429.00	CONTRACTUAL ALLOW	4,491,289.62
NON-COVERD CHARGES	219,159.76	TOTAL MEDICAID LIAB	291,139.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	291,139.38

TOTAL NUMBER OF CLAIMS 54

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,797.30	0.00
MED/SURG SUPPLY	102,625.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,341.00	0.00
CT SCAN	22,876.00	34,818.00
PHYSICAL THERAPY	0.00	4,471.00
EKG/ECG	6,272.00	784.00
IV THERAPY	142,393.00	2,058.00
OPERATING ROOM	715,288.94	76,674.06
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,016.00	0.00
ANESTHESIA	243,540.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,089.00	0.00
RECOVERY ROOM	55,157.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	486,951.00	49,224.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	46,312.00	0.00
OTHER IMAGING SERVICE	3,436.00	3,650.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,040.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	66,017.00	3,897.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	85,355.64	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	62,233.00	13,700.00
MRI SERVICES	5,844.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,127,686.20	29,883.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	559,158.17	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,782,429.00	219,159.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,782,429.00	219,159.76

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	261,836.59	ADJUSTMENTS	0.00
COVERED CHARGES	260,946.59	CONTRACTUAL ALLOW	116,670.88
NON-COVERD CHARGES	890.00	TOTAL MEDICAID LIAB	144,275.71
		LESS: COB	12,725.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	131,550.02

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	93	0	47,430.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	93	0	47,430.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	93	0	47,430.00	0.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,145.59	0.00	OTHER LAB	9,549.00	0.00
MED/SURG SUPPLY	14,418.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,437.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,208.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,240.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,235.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,455.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,717.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,271.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,716.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	167.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,236.00	0.00	NO CC/INVALID REV CODE	0.00	308.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,985.00	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/OBSERV. RM	3,737.00	0.00			

TOTAL ANCILLARY	213,516.59	890.00
TOTAL ACCOMODATIONS	47,430.00	0.00
TOTAL CHARGES	260,946.59	890.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022209072011	07/18/22 - 07/21/22	08/01/22	0.00	231.00	0.00	0.00	0.00
780	2223123009067	02/15/23 - 02/20/23	05/08/23	0.00	77.00	0.00	0.00	0.00
TOTAL				0.00	308.00	0.00	0.00	0.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,171.84	ADJUSTMENTS	0.00
COVERED CHARGES	2,171.84	CONTRACTUAL ALLOW	0.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,171.84
		LESS: COB	2,171.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,020.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,020.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,020.00	0.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	732.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	400.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,151.84	0.00
TOTAL ACCOMODATIONS	1,020.00	0.00
TOTAL CHARGES	2,171.84	0.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	493,577.10	ADJUSTMENTS	19,126.47
COVERED CHARGES	468,130.15	CONTRACTUAL ALLOW	244,402.19
NON-COVERD CHARGES	25,446.95	TOTAL MEDICAID LIAB	223,727.96
		LESS: COB	314.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	223,413.54
		ALL OTHER	203,622.70
		FEE SCHEDULE-LAB	19,706.77
		INJECTABLE DRUGS	84.07

TOTAL NUMBER OF CLAIMS 485

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,048.15	6,995.95
MED/SURG SUPPLY	28,392.00	204.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,615.00	1,116.00
CT SCAN	61,888.00	0.00
PHYSICAL THERAPY	13,757.00	2,584.00
EKG/ECG	3,977.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,269.00	310.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	150,218.00	3,176.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,714.00
SPEECH PATHOLOGY	284.00	148.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,982.00	90.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,300.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,776.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,472.00	1,050.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,049.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	107,687.00	7,974.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	491.00	85.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,925.00	0.00

TOTAL ANCILLARY	468,130.15	25,446.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	468,130.15	25,446.95

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022143042481	05/13/22 - 05/13/22	05/30/22	77.00	0.00	0.00	0.00	20.52
780	5922146000416	05/12/22 - 05/12/22	05/30/22	77.00	0.00	0.00	0.00	20.52
780	2022157029382	05/27/22 - 05/27/22	06/13/22	77.00	0.00	0.00	0.00	20.52
780	2022241043890	08/20/22 - 08/20/22	09/05/22	77.00	0.00	0.00	0.00	20.52
780	2022304035874	10/21/22 - 10/21/22	11/07/22	77.00	0.00	0.00	0.00	20.52
780	2022315077499	11/04/22 - 11/04/22	11/21/22	77.00	0.00	0.00	0.00	20.52
780	2022319065597	11/03/22 - 11/03/22	11/21/22	77.00	0.00	0.00	0.00	20.52
780	2022319065598	11/04/22 - 11/04/22	11/21/22	77.00	0.00	0.00	0.00	20.52
780	2022322081551	11/11/22 - 11/11/22	11/28/22	77.00	0.00	0.00	0.00	20.52
780	2022326086573	11/14/22 - 11/14/22	11/28/22	77.00	0.00	0.00	0.00	20.52
780	2022347050259	11/22/22 - 11/22/22	12/19/22	77.00	0.00	0.00	0.00	20.52
780	2022347050261	12/04/22 - 12/04/22	12/19/22	77.00	0.00	0.00	0.00	20.52
780	2023006102981	12/31/22 - 12/31/22	01/16/23	77.00	0.00	0.00	0.00	20.52
780	2023011053539	01/04/23 - 01/04/23	01/16/23	77.00	0.00	0.00	0.00	20.52
780	2023019095093	01/12/23 - 01/12/23	01/23/23	77.00	0.00	0.00	0.00	20.52
780	2023040057801	01/26/23 - 01/26/23	02/13/23	77.00	0.00	0.00	0.00	20.52
780	2023059051902	02/06/23 - 02/06/23	03/06/23	77.00	0.00	0.00	0.00	20.52
780	2023066064441	02/27/23 - 02/27/23	03/13/23	77.00	0.00	0.00	0.00	20.52
780	5923088000110	02/26/23 - 02/26/23	04/03/23	77.00	0.00	0.00	0.00	20.52
780	5923088000110	03/02/23 - 03/02/23	04/03/23	77.00	0.00	0.00	0.00	20.52
780	2023110116592	04/13/23 - 04/13/23	04/24/23	77.00	0.00	0.00	0.00	20.52
780	5923124001685	08/08/22 - 08/08/22	05/08/23	77.00	0.00	0.00	0.00	20.52
780	5923124001685	08/09/22 - 08/09/22	05/08/23	77.00	0.00	0.00	0.00	20.52
780	5923124001685	08/10/22 - 08/10/22	05/08/23	77.00	0.00	0.00	0.00	20.52
780	5923124001726	04/18/23 - 04/18/23	05/08/23	77.00	0.00	0.00	0.00	20.52
TOTAL				1,925.00	0.00	0.00	0.00	513.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,501.59	ADJUSTMENTS	0.00
COVERED CHARGES	25,166.36	CONTRACTUAL ALLOW	22,366.36
NON-COVERD CHARGES	335.23	TOTAL MEDICAID LIAB	2,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,800.00

TOTAL NUMBER OF CLAIMS 40

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,235.36	107.23
MED/SURG SUPPLY	2,507.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,674.00	186.00
CT SCAN	3,230.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,490.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	953.00	42.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	77.00	0.00

TOTAL ANCILLARY	25,166.36	335.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,166.36	335.23

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022221055343	08/01/22 - 08/01/22	08/15/22	77.00	0.00	0.00	0.00	0.00
TOTAL				77.00	0.00	0.00	0.00	0.00

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,928.36	ADJUSTMENTS	0.00
COVERED CHARGES	10,746.20	CONTRACTUAL ALLOW	5,511.34
NON-COVERD CHARGES	1,182.16	TOTAL MEDICAID LIAB	5,234.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,234.86

TOTAL NUMBER OF CLAIMS 1

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217.20	547.41
MED/SURG SUPPLY	1,481.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	372.00	0.00
CT SCAN	4,125.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	97.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	218.00	355.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,790.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	446.00	14.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	265.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,746.20	1,182.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,746.20	1,182.16

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	245,753.59	ADJUSTMENTS	0.00
COVERED CHARGES	199,243.59	CONTRACTUAL ALLOW	150,712.18
NON-COVERD CHARGES	46,510.00	TOTAL MEDICAID LIAB	48,531.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	48,531.41

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17	0	21,970.12	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	0	21,970.12	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	6	0	10,407.16	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6	0	10,407.16	0.00
TOTAL ACCOMODATIONS	23	0	32,377.28	0.00

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,943.88	46,152.02
MED/SURG SUPPLY	14,938.40	0.00
LABORATORY-GENERAL	66,465.94	0.00
RADIOLOGY-DIAGNOSTIC	2,838.88	0.00
CT SCAN	16,290.41	357.98
PHYSICAL THERAPY	5,834.84	0.00
EKG/ECG	2,228.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	24,537.47	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,946.15	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 SERVICE	1,140.76	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,700.78	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

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

TOTAL ANCILLARY	166,866.31	46,510.00
TOTAL ACCOMODATIONS	32,377.28	0.00
TOTAL CHARGES	199,243.59	46,510.00

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,222,326.72	ADJUSTMENTS	26,902.50
COVERED CHARGES	965,296.36	CONTRACTUAL ALLOW	888,648.29
NON-COVERD CHARGES	257,030.36	TOTAL MEDICAID LIAB	76,648.07
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	76,648.07
		ALL OTHER	65,317.66
		FEE SCHEDULE-LAB	9,467.96
		INJECTABLE DRUGS	1,862.45

TOTAL NUMBER OF CLAIMS 270

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,775.80	18,600.86
MED/SURG SUPPLY	5,220.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,446.59	2,909.98
CT SCAN	42,724.58	108,490.30
PHYSICAL THERAPY	13,242.63	8,574.73
EKG/ECG	16,493.12	891.52
IV THERAPY	0.00	0.00
OPERATING ROOM	11,981.38	56,969.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,685.32	1,546.72
ANESTHESIA	18,154.61	0.00
GI SERVICES	14,109.00	7,544.40
EMERGENCY ROOM	288,379.43	2,635.69
RECOVERY ROOM	15,116.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	2,556.80
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	309.02
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,156.23	1,470.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	559.56	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,071.77	7,376.68
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,643.16	2,700.78
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,227.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	37,742.87	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	268,503.86	13,526.76
MRI SERVICES	11,604.71	7,584.79
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	95,456.89	10,677.58
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	2,664.55
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	965,296.36	257,030.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	965,296.36	257,030.36

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,380.66	ADJUSTMENTS	0.00
COVERED CHARGES	10,661.14	CONTRACTUAL ALLOW	9,872.32
NON-COVERD CHARGES	6,719.52	TOTAL MEDICAID LIAB	788.82
		LESS: COB	788.82
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84.40	5.08
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	6,356.14
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	445.76	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	177.12	307.44
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,409.95	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,543.91	50.86
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,661.14	6,719.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,661.14	6,719.52

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	135,717.67	ADJUSTMENTS	313.28
COVERED CHARGES	108,045.59	CONTRACTUAL ALLOW	105,539.35
NON-COVERD CHARGES	27,672.08	TOTAL MEDICAID LIAB	2,506.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,506.24

TOTAL NUMBER OF CLAIMS 32

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	274.97
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,506.98	0.00
CT SCAN	4,419.96	25,482.42
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,783.04	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,633.79	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,204.24	942.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,497.58	971.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	108,045.59	27,672.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	108,045.59	27,672.08

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,493,617.01	ADJUSTMENTS	16,070.37
COVERED CHARGES	1,092,997.59	CONTRACTUAL ALLOW	994,069.62
NON-COVERD CHARGES	400,619.42	TOTAL MEDICAID LIAB	98,927.97
		LESS: COB	554.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	98,373.67
		ALL OTHER	85,773.42
		FEE SCHEDULE-LAB	11,874.91
		INJECTABLE DRUGS	725.34

TOTAL NUMBER OF CLAIMS 287

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,485.79	30,628.08
MED/SURG SUPPLY	3,553.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,800.30	3,254.26
CT SCAN	53,528.57	107,711.22
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	14,264.32	1,783.04
IV THERAPY	0.00	0.00
OPERATING ROOM	40,390.57	160,302.77
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,010.24	3,020.42
ANESTHESIA	43,749.26	0.00
GI SERVICES	0.00	14,283.00
EMERGENCY ROOM	339,756.70	12,645.32
RECOVERY ROOM	25,474.35	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	665.09
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	309.02
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	18,537.50	2,704.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,690.59	3,488.79
AUDIOLOGY	0.00	0.00
CARDIOLOGY	23,242.32	2,700.78
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	35,284.27	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	307,169.71	6,258.70
MRI SERVICES	24,194.22	22,358.67
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89,072.99	12,527.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	15,978.84
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,792.39	0.00

TOTAL ANCILLARY	1,092,997.59	400,619.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,092,997.59	400,619.42

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2024132015423	12/21/23 - 12/21/23	05/20/24	3,792.39	0.00	0.00	0.00	491.33
TOTAL				3,792.39	0.00	0.00	0.00	491.33

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,881.27	ADJUSTMENTS	78.32
COVERED CHARGES	46,203.85	CONTRACTUAL ALLOW	45,264.01
NON-COVERD CHARGES	677.42	TOTAL MEDICAID LIAB	939.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	939.84

TOTAL NUMBER OF CLAIMS 12

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98.96	55.40
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,835.60	0.00
CT SCAN	4,061.98	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	445.76	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,359.44	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,882.45	101.72
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,519.66	520.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	46,203.85	677.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,203.85	677.42

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,036.23	ADJUSTMENTS	0.00
COVERED CHARGES	52,231.45	CONTRACTUAL ALLOW	47,288.18
NON-COVERD CHARGES	3,804.78	TOTAL MEDICAID LIAB	4,943.27
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,943.27

TOTAL NUMBER OF CLAIMS 1

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.19	2,354.86	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,110.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	323.02	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,578.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,989.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,665.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,505.40	197.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,252.92
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	52,231.45	3,804.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,231.45	3,804.78

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

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,684,117.93	ADJUSTMENTS	19,618.21
COVERED CHARGES	5,413,787.04	CONTRACTUAL ALLOW	-211,568.73
NON-COVERD CHARGES	2,270,330.89	TOTAL MEDICAID LIAB	5,625,355.77
		LESS: COB	973.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,624,382.49

TOTAL NUMBER OF ADMISSIONS 1,244

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,285	0	3,823,300.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,285	0	3,823,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5,285	0	3,823,300.00	0.00

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	766,124.04	2,270,056.88
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	778,084.00	0.00
RADIOLOGY-DIAGNOSTIC	21,262.00	0.00
CT SCAN	12,363.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	247.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,777.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	175.01
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	630.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	99.00

TOTAL ANCILLARY	1,590,487.04	2,270,330.89
TOTAL ACCOMODATIONS	3,823,300.00	0.00
TOTAL CHARGES	5,413,787.04	2,270,330.89

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3006	2223104003966	04/05/23 - 04/11/23	04/17/23	0.00	99.00	0.00	0.00	0.00
TOTAL				0.00	99.00	0.00	0.00	0.00

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,101.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,075.00	CONTRACTUAL ALLOW	4,346.79
NON-COVERD CHARGES	26.00	TOTAL MEDICAID LIAB	7,728.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,728.21
		ALL OTHER	7,697.27
		FEE SCHEDULE-LAB	30.94
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	11,244.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	741.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90.00	26.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,075.00	26.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,075.00	26.00

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,616,816.01	ADJUSTMENTS	817,325.36
COVERED CHARGES	2,608,782.01	CONTRACTUAL ALLOW	1,443,876.26
NON-COVERD CHARGES	8,034.00	TOTAL MEDICAID LIAB	1,164,905.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,164,905.75

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	562	0	1,344,388.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	562	0	1,344,388.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	562	0	1,344,388.00	0.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,417.48	0.00
MED/SURG SUPPLY	35,327.03	0.00
LABORATORY-GENERAL	51,112.00	0.00
RADIOLOGY-DIAGNOSTIC	21,721.00	0.00
CT SCAN	16,863.00	0.00
PHYSICAL THERAPY	328,609.00	0.00
EKG/ECG	3,458.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	37,408.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	70,768.00	0.00
ANESTHESIA	5,630.00	0.00
GI SERVICES	8,105.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,778.00	0.00
LABORATORY PATHOLOGIC	657.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	279,740.00	0.00
SPEECH PATHOLOGY	121,521.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	36.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,893.00	0.00
RECREATIONAL THERAPY	764.00	0.00
EDUCATION & TRAINING	20,034.00	0.00
OTHER THERAPEUTIC SVC	506.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,046.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	8,034.00

TOTAL ANCILLARY	1,264,394.01	8,034.00
TOTAL ACCOMODATIONS	1,344,388.00	0.00
TOTAL CHARGES	2,608,782.01	8,034.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
952	2022217101702	04/01/22 - 04/21/22	08/15/22	0.00	312.00	0.00	0.00	0.00
952	5223233000322	07/20/22 - 08/18/22	08/28/23	0.00	156.00	0.00	0.00	0.00
952	5223233000356	08/02/22 - 09/08/22	08/28/23	0.00	1,560.00	0.00	0.00	0.00
952	5223233000802	12/29/22 - 03/30/23	08/28/23	0.00	936.00	0.00	0.00	0.00
952	5223233000804	10/03/22 - 11/18/22	08/28/23	0.00	2,496.00	0.00	0.00	0.00
952	5223233001073	12/13/22 - 02/03/23	08/28/23	0.00	2,262.00	0.00	0.00	0.00
952	2024024069474	02/10/23 - 03/13/23	01/29/24	0.00	312.00	0.00	0.00	0.00
TOTAL				0.00	8,034.00	0.00	0.00	0.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/22	THROUGH	03/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,507,503.00	ADJUSTMENTS	273,621.28
COVERED CHARGES	3,398,469.50	CONTRACTUAL ALLOW	2,215,210.75
NON-COVERD CHARGES	1,109,033.50	TOTAL MEDICAID LIAB	1,183,258.75
		LESS: COB	10,287.49
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,172,971.26
		ALL OTHER	470,462.82
		FEE SCHEDULE-LAB	10,199.31
		INJECTABLE DRUGS	692,309.13

TOTAL NUMBER OF CLAIMS 981

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,750.00	55,522.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,737.00	1,830.00
CT SCAN	18,257.00	0.00
PHYSICAL THERAPY	105,715.00	154,068.00
EKG/ECG	1,149.00	0.00
IV THERAPY	13,696.00	0.00
OPERATING ROOM	11,382.00	4,065.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,624.00	0.00
ANESTHESIA	146.00	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	57,357.00	0.00
OCCUPATIONAL THERAPY	24,821.00	137,430.00
SPEECH PATHOLOGY	2,863.00	49,657.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	122,221.00	412.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	34,391.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	249,417.00	83,102.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,356.00	14,426.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	984.00
OTHER THERAPEUTIC SVC	232.00	898.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	116,446.50	8,874.50
MRI SERVICES	243,298.00	28,602.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,363,611.00	548,434.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	1,040.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	10,607.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	9,082.00

TOTAL ANCILLARY	3,398,469.50	1,109,033.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,398,469.50	1,109,033.50

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
952	5922262000270	04/26/22 - 04/26/22	09/26/22	0.00	312.00	0.00	0.00	0.00
952	5922262000270	05/13/22 - 05/13/22	09/26/22	0.00	234.00	0.00	0.00	0.00
952	5922262000270	05/03/22 - 05/03/22	09/26/22	0.00	312.00	0.00	0.00	0.00
952	5922262000270	05/05/22 - 05/05/22	09/26/22	0.00	312.00	0.00	0.00	0.00
952	5922262000270	05/12/22 - 05/12/22	09/26/22	0.00	312.00	0.00	0.00	0.00
952	5922262000270	05/16/22 - 05/16/22	09/26/22	0.00	312.00	0.00	0.00	0.00
952	5922262000270	05/18/22 - 05/18/22	09/26/22	0.00	234.00	0.00	0.00	0.00
952	5922276000988	05/11/22 - 05/11/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	04/20/22 - 04/20/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	04/28/22 - 04/28/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	05/02/22 - 05/02/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	05/10/22 - 05/10/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	05/12/22 - 05/12/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	05/16/22 - 05/16/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5922276000988	05/26/22 - 05/26/22	10/10/22	0.00	312.00	0.00	0.00	0.00
952	5923122000397	06/21/22 - 06/21/22	05/08/23	0.00	312.00	0.00	0.00	0.00
952	5923122000397	06/09/22 - 06/09/22	05/08/23	0.00	312.00	0.00	0.00	0.00
952	5923122000397	06/16/22 - 06/16/22	05/08/23	0.00	312.00	0.00	0.00	0.00
952	5923122000397	06/30/22 - 06/30/22	05/08/23	0.00	156.00	0.00	0.00	0.00
952	5923122000397	06/30/22 - 06/30/22	05/08/23	0.00	78.00	0.00	0.00	0.00
952	5923157000130	04/06/23 - 04/06/23	06/12/23	0.00	320.00	0.00	0.00	0.00
952	5923157000130	04/12/23 - 04/12/23	06/12/23	0.00	320.00	0.00	0.00	0.00
952	5923157000130	04/20/23 - 04/20/23	06/12/23	0.00	320.00	0.00	0.00	0.00
952	5923157000130	04/03/23 - 04/03/23	06/12/23	0.00	80.00	0.00	0.00	0.00
952	5923157000130	04/21/23 - 04/21/23	06/12/23	0.00	320.00	0.00	0.00	0.00
952	5923265000816	02/09/23 - 02/09/23	09/25/23	0.00	312.00	0.00	0.00	0.00
952	5923265000816	02/14/23 - 02/14/23	09/25/23	0.00	312.00	0.00	0.00	0.00
952	5923265000816	02/22/23 - 02/22/23	09/25/23	0.00	156.00	0.00	0.00	0.00
952	5923265000816	02/17/23 - 02/17/23	09/25/23	0.00	312.00	0.00	0.00	0.00
952	5923265000816	02/21/23 - 02/21/23	09/25/23	0.00	312.00	0.00	0.00	0.00
952	5923265000816	02/27/23 - 02/27/23	09/25/23	0.00	312.00	0.00	0.00	0.00
952	5923265000816	02/28/23 - 02/28/23	09/25/23	0.00	312.00	0.00	0.00	0.00
TOTAL				0.00	9,082.00	0.00	0.00	0.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	643,409.00	ADJUSTMENTS	0.00
COVERED CHARGES	174,914.00	CONTRACTUAL ALLOW	122,587.03
NON-COVERD CHARGES	468,495.00	TOTAL MEDICAID LIAB	52,326.97
		LESS: COB	52,326.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	588.00	2,055.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	958.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	12,728.00
EKG/ECG	0.00	0.00
IV THERAPY	349.00	0.00
OPERATING ROOM	0.00	813.00
LABOR/DELIVERY 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	4,311.00	0.00
OCCUPATIONAL THERAPY	0.00	10,416.00
SPEECH PATHOLOGY	0.00	6,392.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,458.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	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/OBSERV. RM	41,279.00	47,739.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	3,980.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,270.00	450.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	119,872.00	383,922.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	174,914.00	468,495.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	174,914.00	468,495.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,174,694.00	ADJUSTMENTS	100,287.99
COVERED CHARGES	2,153,460.00	CONTRACTUAL ALLOW	1,796,880.48
NON-COVERD CHARGES	21,234.00	TOTAL MEDICAID LIAB	356,579.52
		LESS: COB	11,142.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	345,437.04

TOTAL NUMBER OF CLAIMS 32

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	468.00	7,391.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,139.00	1,179.00
EKG/ECG	0.00	0.00	MRI SERVICES	12,099.00	12,099.00
IV THERAPY	6,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,053,882.00	435.00
RADIOLOGY THERAPEUTIC	31,824.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	910.00	130.00			

TOTAL ANCILLARY	2,153,460.00	21,234.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,153,460.00	21,234.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,409.00	ADJUSTMENTS	0.00
COVERED CHARGES	44,265.00	CONTRACTUAL ALLOW	33,121.89
NON-COVERD CHARGES	144.00	TOTAL MEDICAID LIAB	11,143.11
		LESS: COB	11,143.11
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	108.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,247.00	36.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	156.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,827.00	0.00
RADIOLOGY THERAPEUTIC	1,035.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	44,265.00	144.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,265.00	144.00

** END OF REPORT **

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,897,093.16	ADJUSTMENTS	736,975.22
COVERED CHARGES	37,863,404.27	CONTRACTUAL ALLOW	34,221,013.45
NON-COVERD CHARGES	33,688.89	TOTAL MEDICAID LIAB	3,642,390.82
		LESS: COB	123,028.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,032.00
		REIMBURSEMENT	3,523,394.38

TOTAL NUMBER OF ADMISSIONS 341

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,433	0	3,533,745.00	0.00
ROUTINE NURSERY	160	0	372,325.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,593	0	3,906,070.50	0.00
SPECIAL CARE SERVICES				
CCU	264	0	1,867,008.00	0.00
ICU	581	0	4,600,176.00	0.00
NICU	126	0	1,426,572.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	971	0	7,893,756.00	0.00
TOTAL ACCOMODATIONS	2,564	0	11,799,826.50	0.00

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,920,896.95	0.00
MED/SURG SUPPLY	1,743,681.40	91.29
LABORATORY-GENERAL	3,763,802.45	0.00
RADIOLOGY-DIAGNOSTIC	707,229.50	0.00
CT SCAN	1,667,159.00	0.00
PHYSICAL THERAPY	234,653.50	0.00
EKG/ECG	192,864.00	0.00
IV THERAPY	201,323.00	0.00
OPERATING ROOM	4,320,365.67	0.00
LABOR/DELIVERY ROOM	684,163.00	0.00
RESPIRATORY SERVICES	2,105,904.09	0.00
ANESTHESIA	987,124.13	0.00
GI SERVICES	195,522.00	0.00
EMERGENCY ROOM	631,299.00	0.00
RECOVERY ROOM	250,642.00	0.00
LABORATORY PATHOLOGIC	108,465.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	156,331.00	0.00
SPEECH PATHOLOGY	117,784.00	0.00
RENAL DIALYSIS	0.00	26,352.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,202.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	76,575.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	405,818.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	85,007.40	1,879.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	556,321.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	253,021.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	623,135.59	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	571,739.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	20,049.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	312,506.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,366.40
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,156,994.09	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	26,063,577.77	33,688.89
TOTAL ACCOMODATIONS	11,799,826.50	0.00
TOTAL CHARGES	37,863,404.27	33,688.89

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,186,681.65	ADJUSTMENTS	0.00
COVERED CHARGES	1,186,576.65	CONTRACTUAL ALLOW	1,120,868.87
NON-COVERD CHARGES	105.00	TOTAL MEDICAID LIAB	65,707.78
		LESS: COB	66,589.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	882.00
		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	55	0	132,495.00	0.00
ROUTINE NURSERY	44	0	186,402.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	99	0	318,897.00	0.00
SPECIAL CARE SERVICES				
CCU	5	0	35,360.00	0.00
ICU	0	0	0.00	0.00
NICU	11	0	124,542.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	16	0	159,902.00	0.00
TOTAL ACCOMODATIONS	115	0	478,799.00	0.00

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,284.20	0.00	OTHER LAB	9,358.00	0.00
MED/SURG SUPPLY	25,459.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	143,390.62	0.00	EDUCATION & TRAINING	2,370.00	0.00
RADIOLOGY-DIAGNOSTIC	14,052.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,263.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,092.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,704.00	0.00	MRI SERVICES	18,381.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,441.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,183.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,932.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,679.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,807.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,089.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,872.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	13,515.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,841.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,660.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,610.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,264.47	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	5,551.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,788.00	105.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,703.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,286.00	0.00			

TOTAL ANCILLARY	707,777.65	105.00
TOTAL ACCOMODATIONS	478,799.00	0.00
TOTAL CHARGES	1,186,576.65	105.00

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,420,864.67	ADJUSTMENTS	36,258.90
COVERED CHARGES	5,544,254.48	CONTRACTUAL ALLOW	4,876,767.49
NON-COVERD CHARGES	876,610.19	TOTAL MEDICAID LIAB	667,486.99
		LESS: COB	2,996.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	664,490.57
		ALL OTHER	586,224.17
		FEE SCHEDULE-LAB	70,233.24
		INJECTABLE DRUGS	8,033.16

TOTAL NUMBER OF CLAIMS 1,321

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,948.43	0.00
MED/SURG SUPPLY	86,720.83	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	252,948.00	2,241.00
CT SCAN	911,289.00	64,108.00
PHYSICAL THERAPY	32,008.00	4,177.00
EKG/ECG	93,411.00	0.00
IV THERAPY	269,297.00	7,847.00
OPERATING ROOM	447,863.14	446,788.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,120.00	4,421.00
ANESTHESIA	172,286.00	1,453.00
GI SERVICES	107,680.01	30,359.99
EMERGENCY ROOM	1,182,980.00	0.00
RECOVERY ROOM	63,351.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	36,534.00	162,645.00
OCCUPATIONAL THERAPY	782.00	788.00
SPEECH PATHOLOGY	0.00	2,966.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	322.00	644.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	119,256.20	16,656.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,938.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,617.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	46,578.00	17,195.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	59,556.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	247,108.47	39,679.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	62,787.00	4,800.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	848,505.59	13,864.55
MRI SERVICES	211,448.00	18,842.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	83,531.80	37,134.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	13,254.01	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,134.00	0.00

TOTAL ANCILLARY	5,544,254.48	876,610.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,544,254.48	876,610.19

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022217003778	07/05/22 - 07/05/22	08/08/22	159.00	0.00	0.00	0.00	20.52
780	2022217003951	07/01/22 - 07/01/22	08/08/22	159.00	0.00	0.00	0.00	20.52
780	2022217105111	07/05/22 - 07/05/22	08/15/22	159.00	0.00	0.00	0.00	20.52
780	2022235079842	08/19/22 - 08/19/22	08/29/22	159.00	0.00	0.00	0.00	20.52
780	2022248019540	08/18/22 - 08/18/22	09/12/22	159.00	0.00	0.00	0.00	20.52
780	2022248019540	08/27/22 - 08/27/22	09/12/22	159.00	0.00	0.00	0.00	20.52
780	2022269040074	07/25/22 - 07/25/22	10/03/22	159.00	0.00	0.00	0.00	20.52
780	2022279000158	09/30/22 - 09/30/22	10/10/22	159.00	0.00	0.00	0.00	20.52
780	2022279000168	09/27/22 - 09/27/22	10/10/22	159.00	0.00	0.00	0.00	20.52
780	2022311060412	10/06/22 - 10/06/22	11/14/22	159.00	0.00	0.00	0.00	20.52
780	2022313091670	10/30/22 - 10/30/22	11/14/22	159.00	0.00	0.00	0.00	20.52
780	2022326029564	10/15/22 - 10/15/22	11/28/22	159.00	0.00	0.00	0.00	20.52
780	2022339047410	11/22/22 - 11/22/22	12/12/22	159.00	0.00	0.00	0.00	20.52
780	2023002019130	10/11/22 - 10/11/22	01/09/23	159.00	0.00	0.00	0.00	20.52
780	2023002019264	11/01/22 - 11/01/22	01/09/23	159.00	0.00	0.00	0.00	20.52
780	2023009045545	12/15/22 - 12/15/22	01/16/23	159.00	0.00	0.00	0.00	20.52
780	2023023045238	01/18/23 - 01/18/23	01/30/23	159.00	0.00	0.00	0.00	20.52
780	2023037054442	01/11/23 - 01/11/23	02/13/23	159.00	0.00	0.00	0.00	20.52
780	2023051037921	12/04/22 - 12/04/22	02/27/23	159.00	0.00	0.00	0.00	20.52
780	2023058050530	09/04/22 - 09/04/22	03/06/23	159.00	0.00	0.00	0.00	20.52
780	2023058050530	09/18/22 - 09/18/22	03/06/23	159.00	0.00	0.00	0.00	20.52
780	2023059072312	07/22/22 - 07/22/22	03/06/23	159.00	0.00	0.00	0.00	20.52
780	2023066028818	02/11/23 - 02/11/23	03/13/23	159.00	0.00	0.00	0.00	20.52
780	2023068126242	02/20/23 - 02/20/23	03/13/23	159.00	0.00	0.00	0.00	20.52
780	2023095094672	03/29/23 - 03/29/23	04/10/23	159.00	0.00	0.00	0.00	20.52
780	2023109077941	04/14/23 - 04/14/23	04/24/23	159.00	0.00	0.00	0.00	20.52
TOTAL				4,134.00	0.00	0.00	0.00	533.52

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	270,933.77	ADJUSTMENTS	0.00
COVERED CHARGES	194,012.49	CONTRACTUAL ALLOW	171,313.61
NON-COVERD CHARGES	76,921.28	TOTAL MEDICAID LIAB	22,698.88
		LESS: COB	22,698.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,809.60	330.00
MED/SURG SUPPLY	12,038.56	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,004.00	0.00
CT SCAN	14,778.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	784.00	0.00
IV THERAPY	4,852.00	0.00
OPERATING ROOM	43,325.10	75,115.90
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	754.00	0.00
ANESTHESIA	49,336.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,152.00	0.00
RECOVERY ROOM	12,268.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,426.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,639.83	103.28
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,845.40	1,372.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	194,012.49	76,921.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,012.49	76,921.28

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	130,709.90	ADJUSTMENTS	0.00
COVERED CHARGES	130,055.20	CONTRACTUAL ALLOW	127,302.87
NON-COVERD CHARGES	654.70	TOTAL MEDICAID LIAB	2,752.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,752.33

TOTAL NUMBER OF CLAIMS 41

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,580.60	0.00
MED/SURG SUPPLY	110.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,811.00	0.00
CT SCAN	28,249.00	0.00
PHYSICAL THERAPY	0.00	350.00
EKG/ECG	2,352.00	0.00
IV THERAPY	3,845.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	69,118.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,405.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,525.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,813.00	253.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	246.60	51.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	130,055.20	654.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	130,055.20	654.70

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,435,972.42	ADJUSTMENTS	20,515.41
COVERED CHARGES	2,184,812.27	CONTRACTUAL ALLOW	2,056,592.47
NON-COVERD CHARGES	251,160.15	TOTAL MEDICAID LIAB	128,219.80
		LESS: COB	7,425.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	120,794.16

TOTAL NUMBER OF CLAIMS 25

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,762.10	0.00
MED/SURG SUPPLY	131,116.79	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,766.00	910.00
CT SCAN	4,795.00	0.00
PHYSICAL THERAPY	350.00	627.00
EKG/ECG	784.00	0.00
IV THERAPY	10,510.00	966.00
OPERATING ROOM	600,293.25	167,206.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	174,388.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,089.00	0.00
RECOVERY ROOM	43,849.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	258,247.00	26,504.00
OCCUPATIONAL THERAPY	386.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,160.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	526.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	13,337.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,011.82	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,393.00	3,208.00
MRI SERVICES	0.00	3,972.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	627,899.50	33,902.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	231,011.81	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,184,812.27	251,160.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,184,812.27	251,160.15

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	187,570.91	ADJUSTMENTS	0.00
COVERED CHARGES	138,838.51	CONTRACTUAL ALLOW	123,452.09
NON-COVERD CHARGES	48,732.40	TOTAL MEDICAID LIAB	15,386.42
		LESS: COB	15,386.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,748.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,290.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,109.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,264.00	45,830.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,958.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,608.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	874.30	2,902.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,985.70	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	138,838.51	48,732.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	138,838.51	48,732.40

** END OF REPORT **

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,598,536.29	ADJUSTMENTS	173,054.97
COVERED CHARGES	1,582,976.29	CONTRACTUAL ALLOW	1,087,343.44
NON-COVERD CHARGES	15,560.00	TOTAL MEDICAID LIAB	495,632.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	495,632.85

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	78	0	155,291.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	78	0	155,291.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	35	0	95,354.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	35	0	95,354.00	0.00
TOTAL ACCOMODATIONS	113	0	250,645.00	0.00

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,021.48	0.00	OTHER LAB	3,257.00	0.00
MED/SURG SUPPLY	44,555.00	1,320.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	157,332.00	0.00	EDUCATION & TRAINING	2,322.00	0.00
RADIOLOGY-DIAGNOSTIC	10,312.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,037.00	9,119.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,474.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,884.00	0.00	MRI SERVICES	21,923.00	0.00
IV THERAPY	13,795.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	494,603.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	131,949.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,211.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,387.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	36,748.00	0.00	INJECTABLE DRUGS	107,275.81	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,839.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,248.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,516.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,683.00	5,121.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,064.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,577.00	0.00			

TOTAL ANCILLARY	1,332,331.29	15,560.00
TOTAL ACCOMODATIONS	250,645.00	0.00
TOTAL CHARGES	1,582,976.29	15,560.00

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,504,132.36	ADJUSTMENTS	443,701.34
COVERED CHARGES	7,603,025.35	CONTRACTUAL ALLOW	6,595,990.68
NON-COVERD CHARGES	901,107.01	TOTAL MEDICAID LIAB	1,007,034.67
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,007,034.67
		ALL OTHER	654,144.39
		FEE SCHEDULE-LAB	30,313.35
		INJECTABLE DRUGS	322,576.93

TOTAL NUMBER OF CLAIMS 619

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,990.56	2,221.74
MED/SURG SUPPLY	68,487.00	6,792.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,895.00	2,980.00
CT SCAN	1,153,573.00	201,169.00
PHYSICAL THERAPY	4,840.00	7,280.00
EKG/ECG	13,045.00	0.00
IV THERAPY	208,601.00	1,246.00
OPERATING ROOM	286,635.00	83,680.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,141.00	0.00
ANESTHESIA	294,020.00	0.00
GI SERVICES	27,113.00	5,727.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	324,551.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,148,933.00	214,337.00
OCCUPATIONAL THERAPY	3,936.00	3,029.00
SPEECH PATHOLOGY	5,993.00	2,540.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	172,096.00	4,931.00
BLOOD	0.00	649.00
BLOOD STORAGE & PRO.	15,377.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	42,556.00	12,076.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,817.00	38,356.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	66,975.00	5,509.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,841.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,116.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	517,775.00	7,176.00
MRI SERVICES	372,212.00	62,821.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,713,296.79	233,899.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,636.00	3,572.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,690.00	0.00

TOTAL ANCILLARY	7,603,025.35	901,107.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,603,025.35	901,107.01

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022288025276	10/03/22 - 10/03/22	10/24/22	104.00	0.00	0.00	0.00	20.52
780	2022308032171	10/18/22 - 10/18/22	11/07/22	104.00	0.00	0.00	0.00	20.52
780	2022326030563	11/11/22 - 11/11/22	11/28/22	114.00	0.00	0.00	0.00	20.52
780	2022336089004	11/18/22 - 11/18/22	12/12/22	114.00	0.00	0.00	0.00	20.52
780	2023018009975	01/05/23 - 01/05/23	01/23/23	114.00	0.00	0.00	0.00	20.52
780	2023044045388	02/01/23 - 02/01/23	02/20/23	114.00	0.00	0.00	0.00	20.52
780	2023045064259	02/03/23 - 02/03/23	02/20/23	114.00	0.00	0.00	0.00	20.52
780	2023060093549	02/16/23 - 02/16/23	03/06/23	114.00	0.00	0.00	0.00	20.52
780	2023073069650	03/01/23 - 03/01/23	03/20/23	114.00	0.00	0.00	0.00	20.52
780	2023088083995	03/17/23 - 03/17/23	04/03/23	114.00	0.00	0.00	0.00	20.52
780	2023111021657	04/05/23 - 04/05/23	04/24/23	114.00	0.00	0.00	0.00	20.52
780	2023117096597	04/13/23 - 04/13/23	05/01/23	114.00	0.00	0.00	0.00	20.52
780	2023130083076	04/26/23 - 04/26/23	05/15/23	114.00	0.00	0.00	0.00	20.52
780	2023131096779	05/01/23 - 05/01/23	05/15/23	114.00	0.00	0.00	0.00	20.52
780	2023138017789	05/03/23 - 05/03/23	05/22/23	114.00	0.00	0.00	0.00	20.52
TOTAL				1,690.00	0.00	0.00	0.00	307.80

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,426,668.77	ADJUSTMENTS	427,632.83
COVERED CHARGES	6,294,004.20	CONTRACTUAL ALLOW	5,543,627.37
NON-COVERD CHARGES	132,664.57	TOTAL MEDICAID LIAB	750,376.83
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	750,376.83

TOTAL NUMBER OF CLAIMS 93

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,903.42	0.00
MED/SURG SUPPLY	106,578.00	57.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,059.00	21,642.00
CT SCAN	0.00	18,164.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,036.00	0.00
IV THERAPY	90,333.00	893.00
OPERATING ROOM	365,447.68	48,276.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	970.00	0.00
ANESTHESIA	78,017.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	60,318.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	925,381.00	3,098.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	648.00	919.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,787.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,592.00	238.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	51.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	88,657.00	226.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,417,527.10	39,100.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	131,750.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,294,004.20	132,664.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,294,004.20	132,664.57

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

SOUTHEASTERN REGIONAL MEDICAL CENTER, INC
600 CELEBRATE LIFE PARKWAY
NEWNAN,GA 30265-8001

PROVIDER NUMBER
003136026A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,335,429.86	ADJUSTMENTS	712,602.96
COVERED CHARGES	4,334,642.46	CONTRACTUAL ALLOW	2,174,909.85
NON-COVERD CHARGES	787.40	TOTAL MEDICAID LIAB	2,159,732.61
		LESS: COB	12,021.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,147,711.05

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	930	0	1,298,912.40	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	930	0	1,298,912.40	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	930	0	1,298,912.40	0.00

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	910,839.00	0.00
MED/SURG SUPPLY	176,851.02	0.00
LABORATORY-GENERAL	288,402.06	0.00
RADIOLOGY-DIAGNOSTIC	73,798.83	0.00
CT SCAN	12,966.95	0.00
PHYSICAL THERAPY	89,387.52	0.00
EKG/ECG	5,471.25	0.00
IV THERAPY	1,193.81	602.00
OPERATING ROOM	9,104.17	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	942,379.72	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,129.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	154,332.43	0.00
SPEECH PATHOLOGY	88,969.34	0.00
RENAL DIALYSIS	279,706.80	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	82.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	185.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	115.36	0.00

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

TOTAL ANCILLARY	3,035,730.06	787.40
TOTAL ACCOMODATIONS	1,298,912.40	0.00
TOTAL CHARGES	4,334,642.46	787.40

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/23	THROUGH	12/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

WELLSTAR MCG HEALTH WARM SPRINGS, INC
6135 ROOSEVELT HIGHWAY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
003214227A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,997,857.14	ADJUSTMENTS	304,342.85
COVERED CHARGES	1,993,546.71	CONTRACTUAL ALLOW	1,575,423.18
NON-COVERD CHARGES	4,310.43	TOTAL MEDICAID LIAB	418,123.53
		LESS: COB	50,597.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	367,525.96

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	222	0	1,114,376.56	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	222	0	1,114,376.56	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	222	0	1,114,376.56	0.00

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	384,244.93	0.00
MED/SURG SUPPLY	245,030.31	0.00
LABORATORY-GENERAL	61,099.06	0.00
RADIOLOGY-DIAGNOSTIC	4,973.07	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	32,689.63	0.00
EKG/ECG	115,225.47	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,406.32	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,537.29	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	1,064.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	22,483.19	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,711.46	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	704.80	0.00
OTHER THERAPEUTIC SVC	0.00	4,310.43
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	879,170.15	4,310.43
TOTAL ACCOMODATIONS	1,114,376.56	0.00
TOTAL CHARGES	1,993,546.71	4,310.43

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/22	THROUGH	03/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/22	THROUGH	03/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/22	THROUGH	03/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - AUGUSTA, INC.
1537 WALTON WAY
AUGUSTA,GA 30904-3764

PROVIDER NUMBER
003222162A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,694,982.22	ADJUSTMENTS	812,088.80
COVERED CHARGES	21,167,175.14	CONTRACTUAL ALLOW	18,190,135.60
NON-COVERD CHARGES	527,807.08	TOTAL MEDICAID LIAB	2,977,039.54
		LESS: COB	24,718.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,952,320.66

TOTAL NUMBER OF ADMISSIONS 48

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,602	0	9,764,969.83	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,602	0	9,764,969.83	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,602	0	9,764,969.83	0.00

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,617,838.05	0.00
MED/SURG SUPPLY	1,012,686.76	0.00
LABORATORY-GENERAL	1,119,154.64	0.00
RADIOLOGY-DIAGNOSTIC	92,063.33	0.00
CT SCAN	0.00	86,103.10
PHYSICAL THERAPY	359,281.14	0.00
EKG/ECG	1,159,638.56	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	10,344.54	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,157,609.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	451.86	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	370,223.64	0.00
SPEECH PATHOLOGY	65,457.17	0.00
RENAL DIALYSIS	337,020.48	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,068.39	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	15,229.70	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,048.12	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	34,155.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,480.48	0.00
OTHER THERAPEUTIC SVC	0.00	396,216.50
SPECIAL CHARGES	14,873.10	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	45,487.48
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,579.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,402,205.31	527,807.08
TOTAL ACCOMODATIONS	9,764,969.83	0.00
TOTAL CHARGES	21,167,175.14	527,807.08

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

REGENCY HOSPITAL COMPANY OF MACON, LLC
535 COLISEUM DR
MACON,GA 31217-0104

PROVIDER NUMBER
003225152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 11/01/22 THROUGH 10/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/22	THROUGH	04/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,260,556.51	ADJUSTMENTS	841,822.05
COVERED CHARGES	6,063,866.01	CONTRACTUAL ALLOW	5,093,650.47
NON-COVERD CHARGES	196,690.50	TOTAL MEDICAID LIAB	970,215.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	970,215.54

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	529	0	2,477,029.18	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	529	0	2,477,029.18	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	529	0	2,477,029.18	0.00

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242,176.14	0.00
MED/SURG SUPPLY	253,535.84	0.00
LABORATORY-GENERAL	120,653.62	0.00
RADIOLOGY-DIAGNOSTIC	74,425.94	0.00
CT SCAN	0.00	59,067.34
PHYSICAL THERAPY	107,188.07	0.00
EKG/ECG	274,272.85	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	51,107.94	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,237,040.05	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	102,450.63	0.00
SPEECH PATHOLOGY	68,464.77	0.00
RENAL DIALYSIS	34,420.20	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,242.98	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,321.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,287.89	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	117,329.72
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,248.91	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	20,293.44
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,586,836.83	196,690.50
TOTAL ACCOMODATIONS	2,477,029.18	0.00
TOTAL CHARGES	6,063,866.01	196,690.50

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/22	THROUGH	04/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

SELECT SPECIALTY HOSPITAL - SAVANNAH, INC.
5353 REYNOLDS ST
SAVANNAH,GA 31405-6015

PROVIDER NUMBER
003229133A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,477,943.18	ADJUSTMENTS	1,064,992.35
COVERED CHARGES	2,475,053.18	CONTRACTUAL ALLOW	1,107,424.32
NON-COVERD CHARGES	2,890.00	TOTAL MEDICAID LIAB	1,367,628.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,367,628.86

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	970	0	1,365,893.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	970	0	1,365,893.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	970	0	1,365,893.00	0.00

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242,729.47	0.00	OTHER LAB	5,442.01	0.00
MED/SURG SUPPLY	28,375.00	318.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	58,882.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,080.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,572.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	308,447.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,118.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	343,624.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	68,475.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	32,217.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,770.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,109,160.18	2,890.00
TOTAL ACCOMODATIONS	1,365,893.00	0.00
TOTAL CHARGES	2,475,053.18	2,890.00

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	03/01/22	THROUGH	02/28/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

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

PIEDMONT HEALTHCARE ENCOMPASS HEALTH REH
2200 PATRICK HENRY PARKWAY
MCDONOUGH,GA 30253-4207

PROVIDER NUMBER
003259617A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,326,001.48	ADJUSTMENTS	262,131.04
COVERED CHARGES	15,320,961.48	CONTRACTUAL ALLOW	11,869,917.48
NON-COVERD CHARGES	5,040.00	TOTAL MEDICAID LIAB	3,451,044.00
		LESS: COB	44,741.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	41,000.00
		REIMBURSEMENT	3,447,302.17

TOTAL NUMBER OF ADMISSIONS 458

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,891	0	2,037,192.00	0.00
ROUTINE NURSERY	93	0	74,347.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,984	0	2,111,539.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	178	0	430,144.00	0.00
NICU	4	0	10,816.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	182	0	440,960.00	0.00
TOTAL ACCOMODATIONS	2,166	0	2,552,499.00	0.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,443,332.27	0.00
MED/SURG SUPPLY	8,940.00	0.00
LABORATORY-GENERAL	2,222,047.00	0.00
RADIOLOGY-DIAGNOSTIC	207,915.00	0.00
CT SCAN	955,428.00	0.00
PHYSICAL THERAPY	308,160.00	0.00
EKG/ECG	70,770.00	0.00
IV THERAPY	111,307.00	0.00
OPERATING ROOM	1,127,495.00	0.00
LABOR/DELIVERY ROOM	187,240.00	0.00
RESPIRATORY SERVICES	744,383.00	0.00
ANESTHESIA	277,984.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	991,541.00	0.00
RECOVERY ROOM	188,035.00	0.00
LABORATORY PATHOLOGIC	32,878.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	40,610.00	0.00
SPEECH PATHOLOGY	31,348.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	774.00	3,958.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	65,212.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	284,655.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,978.00	0.00
AUDIOLOGY	31,432.00	0.00
CARDIOLOGY	175,540.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,278.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	299,459.00	932.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	66,555.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	103,963.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,214,041.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	565,161.47	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	150.00

TOTAL ANCILLARY	12,768,462.48	5,040.00
TOTAL ACCOMODATIONS	2,552,499.00	0.00
TOTAL CHARGES	15,320,961.48	5,040.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022229055259	08/08/22 - 08/10/22	08/22/22	0.00	50.00	0.00	0.00	0.00
780	2022319011454	10/25/22 - 11/07/22	11/21/22	0.00	50.00	0.00	0.00	0.00
780	2023111063938	04/13/23 - 04/14/23	04/24/23	0.00	50.00	0.00	0.00	0.00
TOTAL				0.00	150.00	0.00	0.00	0.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,706.50	ADJUSTMENTS	0.00
COVERED CHARGES	65,706.50	CONTRACTUAL ALLOW	61,727.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,979.36
		LESS: COB	3,979.36
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	9	0	9,315.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9	0	9,315.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	6,864.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	6,864.00	0.00
TOTAL ACCOMODATIONS	12	0	16,179.00	0.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,058.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,789.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	996.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	992.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,603.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,786.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,931.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,146.00	0.00			

TOTAL ANCILLARY	49,527.50	0.00
TOTAL ACCOMODATIONS	16,179.00	0.00
TOTAL CHARGES	65,706.50	0.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,066,509.29	ADJUSTMENTS	476,239.96
COVERED CHARGES	9,255,566.78	CONTRACTUAL ALLOW	7,630,744.94
NON-COVERD CHARGES	810,942.51	TOTAL MEDICAID LIAB	1,624,821.84
		LESS: COB	2,561.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,622,260.76
		ALL OTHER	1,177,052.00
		FEE SCHEDULE-LAB	120,069.49
		INJECTABLE DRUGS	325,139.27

TOTAL NUMBER OF CLAIMS 2,882

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	401,747.90	5,334.50
MED/SURG SUPPLY	1,593.67	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	233,876.00	4,936.00
CT SCAN	1,062,004.00	31,605.00
PHYSICAL THERAPY	110,285.00	6,379.00
EKG/ECG	83,635.00	2,712.00
IV THERAPY	1,007,968.50	4,121.00
OPERATING ROOM	683,719.84	162,418.16
LABOR/DELIVERY ROOM	13,760.00	0.00
RESPIRATORY SERVICES	30,842.00	11,114.00
ANESTHESIA	252,014.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,174,651.00	6,069.00
RECOVERY ROOM	334,363.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	93,568.00	0.00
OCCUPATIONAL THERAPY	5,689.00	1,016.00
SPEECH PATHOLOGY	2,126.00	3,123.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,930.00	176.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	126,142.00	8,316.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	84,491.00	2,080.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	69,569.00	20,828.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	71,691.00	18,219.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,565.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	86,633.66	17,482.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	45,408.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	136.00
OTHER THERAPEUTIC SVC	0.00	4,318.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,320,098.40	100,096.00
MRI SERVICES	148,557.00	3,280.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,665,398.40	397,183.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	95,090.41	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	150.00	0.00

TOTAL ANCILLARY	9,255,566.78	810,942.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,255,566.78	810,942.51

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022244065843	08/26/22 - 08/26/22	09/05/22	50.00	0.00	0.00	0.00	20.52
780	5922271001312	09/07/22 - 09/07/22	10/03/22	50.00	0.00	0.00	0.00	20.52
780	2023093025468	03/24/23 - 03/24/23	04/10/23	50.00	0.00	0.00	0.00	20.52
TOTAL				150.00	0.00	0.00	0.00	61.56

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	237,716.10	ADJUSTMENTS	0.00
COVERED CHARGES	93,182.94	CONTRACTUAL ALLOW	77,829.05
NON-COVERD CHARGES	144,533.16	TOTAL MEDICAID LIAB	15,353.89
		LESS: COB	15,353.89
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,047.25	8,715.75
MED/SURG SUPPLY	21.35	31.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,940.00	347.00
CT SCAN	2,374.00	4,014.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	3,518.00	0.00
OPERATING ROOM	15,805.34	41,485.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,354.00	812.00
ANESTHESIA	16,362.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,072.00	0.00
RECOVERY ROOM	14,346.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	996.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,896.00	1,826.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	6,771.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,006.00	5,704.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,493.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,202.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	254.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,872.00	479.00
MRI SERVICES	1,230.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,648.00	30,084.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	44,009.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	93,182.94	144,533.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,182.94	144,533.16

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	109,107.63	ADJUSTMENTS	78.32
COVERED CHARGES	106,592.63	CONTRACTUAL ALLOW	101,345.19
NON-COVERD CHARGES	2,515.00	TOTAL MEDICAID LIAB	5,247.44
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,247.44

TOTAL NUMBER OF CLAIMS 67

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,245.63	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,268.00	0.00
CT SCAN	18,248.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	452.00	0.00
IV THERAPY	13,003.00	0.00
OPERATING ROOM	1,460.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	46,286.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,721.00	1,466.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,909.00	1,049.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	106,592.63	2,515.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	106,592.63	2,515.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,153.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,430.00	CONTRACTUAL ALLOW	2,351.68
NON-COVERD CHARGES	7,723.00	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,723.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	709.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,690.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,430.00	7,723.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,430.00	7,723.00

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,273,381.75	ADJUSTMENTS	164,796.00
COVERED CHARGES	3,066,649.60	CONTRACTUAL ALLOW	2,627,193.60
NON-COVERD CHARGES	206,732.15	TOTAL MEDICAID LIAB	439,456.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	439,456.00

TOTAL NUMBER OF CLAIMS 80

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,607.80	0.00
MED/SURG SUPPLY	869.02	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,906.00	2,368.00
CT SCAN	0.00	11,606.00
PHYSICAL THERAPY	2,249.00	15,515.00
EKG/ECG	3,390.00	226.00
IV THERAPY	96,282.00	0.00
OPERATING ROOM	480,969.94	57,683.06
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,857.00	1,320.00
ANESTHESIA	131,240.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,250.00	0.00
RECOVERY ROOM	77,784.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	59,722.00	0.00
OCCUPATIONAL THERAPY	2,583.00	5,767.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	203.00	160.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,827.00	882.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,582.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	39,817.27	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	52,065.00	12,713.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,504,790.52	98,492.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	486,655.05	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,066,649.60	206,732.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,066,649.60	206,732.15

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,384,385.27	ADJUSTMENTS	13,226.40
COVERED CHARGES	1,381,430.83	CONTRACTUAL ALLOW	578,329.16
NON-COVERD CHARGES	2,954.44	TOTAL MEDICAID LIAB	803,101.67
		LESS: COB	10,676.58
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	792,425.09

TOTAL NUMBER OF ADMISSIONS 145

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	937	0	520,340.75	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	937	0	520,340.75	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	937	0	520,340.75	0.00

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	250,332.98	0.00	OTHER LAB	1,094.60	0.00
MED/SURG SUPPLY	15,687.13	40.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	161,900.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,675.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,998.00	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,519.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,220.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	227,932.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,786.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	93,556.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,890.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	953.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	788.83	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	569.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,209.20	1,014.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,975.50	0.00			

TOTAL ANCILLARY	861,090.08	2,954.44
TOTAL ACCOMODATIONS	520,340.75	0.00
TOTAL CHARGES	1,381,430.83	2,954.44

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/22	THROUGH	08/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,412,553.20	ADJUSTMENTS	14,120.52
COVERED CHARGES	1,301,019.45	CONTRACTUAL ALLOW	830,770.71
NON-COVERD CHARGES	111,533.75	TOTAL MEDICAID LIAB	470,248.74
		LESS: COB	33.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	470,215.47
		ALL OTHER	430,014.99
		FEE SCHEDULE-LAB	33,185.84
		INJECTABLE DRUGS	7,014.64

TOTAL NUMBER OF CLAIMS 840

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,075.78	1,688.60
MED/SURG SUPPLY	17,909.54	0.00
LABORATORY-GENERAL	0.00	30.00
RADIOLOGY-DIAGNOSTIC	48,398.83	3,697.38
CT SCAN	198,965.75	10,819.25
PHYSICAL THERAPY	43,707.10	7,328.40
EKG/ECG	21,727.50	0.00
IV THERAPY	251,944.20	1,417.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	41,484.00	689.00
ANESTHESIA	3,535.00	0.00
GI SERVICES	20,370.00	8,861.00
EMERGENCY ROOM	219,454.79	1,239.23
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	16,880.00	4,262.00
SPEECH PATHOLOGY	1,812.50	1,196.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	477.00
PSYCHIATRIC SERVICES	16,146.00	26,940.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,401.80	1,283.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,606.40	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,744.00	996.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	22,358.20	3,832.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	40,876.72	505.68

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,670.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	172,310.70	16,624.75
MRI SERVICES	54,174.60	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,465.44	19,646.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,301,019.45	111,533.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,301,019.45	111,533.75

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,561.10	ADJUSTMENTS	0.00
COVERED CHARGES	11,899.66	CONTRACTUAL ALLOW	7,815.91
NON-COVERD CHARGES	661.44	TOTAL MEDICAID LIAB	4,083.75
		LESS: COB	4,083.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.68	0.00
MED/SURG SUPPLY	555.73	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	220.00	0.00
CT SCAN	1,365.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	465.00	0.00
IV THERAPY	2,045.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,033.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,697.68	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 SERVICE	335.00	500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,058.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,531.75	123.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	560.82	38.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,899.66	661.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,899.66	661.44

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,147.11	ADJUSTMENTS	78.32
COVERED CHARGES	81,395.89	CONTRACTUAL ALLOW	76,540.05
NON-COVERD CHARGES	5,751.22	TOTAL MEDICAID LIAB	4,855.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,855.84

TOTAL NUMBER OF CLAIMS 62

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	688.11	0.00
MED/SURG SUPPLY	505.66	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,604.00	0.00
CT SCAN	18,126.00	4,641.60
PHYSICAL THERAPY	758.40	168.75
EKG/ECG	1,046.25	0.00
IV THERAPY	11,250.55	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,317.25	77.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,749.68	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,527.80	685.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,822.19	178.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	81,395.89	5,751.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,395.89	5,751.22

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	829.88	ADJUSTMENTS	0.00
COVERED CHARGES	829.88	CONTRACTUAL ALLOW	751.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	78.32
		LESS: COB	78.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	239.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	590.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	829.88	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	829.88	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	106,689.52	ADJUSTMENTS	0.00
COVERED CHARGES	99,988.12	CONTRACTUAL ALLOW	68,638.82
NON-COVERD CHARGES	6,701.40	TOTAL MEDICAID LIAB	31,349.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	31,349.30

TOTAL NUMBER OF CLAIMS 6

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,134.64	304.53
MED/SURG SUPPLY	1,833.87	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938.61	0.00
CT SCAN	12,582.60	1,135.00
PHYSICAL THERAPY	0.00	164.00
EKG/ECG	1,472.50	0.00
IV THERAPY	48,590.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	450.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,109.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	286.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,540.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,036.16	23.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,348.25	703.00
MRI SERVICES	2,130.00	2,453.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,821.19	1,632.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	99,988.12	6,701.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,988.12	6,701.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,022,906.22	ADJUSTMENTS	747,510.74
COVERED CHARGES	32,976,849.22	CONTRACTUAL ALLOW	24,080,709.38
NON-COVERD CHARGES	46,057.00	TOTAL MEDICAID LIAB	8,896,139.84
		LESS: COB	111,375.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,764.00
		REIMBURSEMENT	8,786,528.63

TOTAL NUMBER OF ADMISSIONS 1,247

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,080	0	9,647,913.00	0.00
ROUTINE NURSERY	84	0	67,610.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,164	0	9,715,523.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	673	0	1,386,060.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	673	0	1,386,060.00	0.00
TOTAL ACCOMODATIONS	7,837	0	11,101,583.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,944,742.75	0.00
MED/SURG SUPPLY	1,911,324.50	0.00
LABORATORY-GENERAL	4,539,513.64	1,104.00
RADIOLOGY-DIAGNOSTIC	414,730.00	0.00
CT SCAN	1,539,143.01	145.00
PHYSICAL THERAPY	152,270.00	0.00
EKG/ECG	137,610.00	230.00
IV THERAPY	169,483.00	145.00
OPERATING ROOM	2,234,236.00	0.00
LABOR/DELIVERY ROOM	90,981.00	0.00
RESPIRATORY SERVICES	881,025.00	125.00
ANESTHESIA	157,996.00	364.00
GI SERVICES	123,729.00	2,382.00
EMERGENCY ROOM	1,324,532.00	0.00
RECOVERY ROOM	160,702.32	0.00
LABORATORY PATHOLOGIC	120,654.00	0.00
RADIOLOGY THERAPEUTIC	53,827.00	0.00
OCCUPATIONAL THERAPY	106,595.00	0.00
SPEECH PATHOLOGY	58,489.00	0.00
RENAL DIALYSIS	148,150.00	618.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	292.00	7,502.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	109,689.00	21,147.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	315,817.00	924.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,848.00	0.00
AUDIOLOGY	31,629.00	0.00
CARDIOLOGY	1,316,156.00	2,808.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,068.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	365,617.00	1,496.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	44,071.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	225,846.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,923.00	180.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	6,818.00
IMPL DEV CHARGE PATIENTS	1,121,577.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	69.00

TOTAL ANCILLARY	21,875,266.22	46,057.00
TOTAL ACCOMODATIONS	11,101,583.00	0.00
TOTAL CHARGES	32,976,849.22	46,057.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023062087142	02/04/23 - 02/23/23	03/13/23	0.00	69.00	0.00	0.00	0.00
TOTAL				0.00	69.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,215.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,215.00	CONTRACTUAL ALLOW	21,003.52
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,211.48
		LESS: COB	9,211.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11	0	16,609.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	16,609.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	16,609.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,571.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	646.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,883.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,378.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	128.00	0.00			

TOTAL ANCILLARY	13,606.00	0.00
TOTAL ACCOMODATIONS	16,609.00	0.00
TOTAL CHARGES	30,215.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,172,719.52	ADJUSTMENTS	896,674.06
COVERED CHARGES	16,934,095.56	CONTRACTUAL ALLOW	13,074,511.73
NON-COVERD CHARGES	1,238,623.96	TOTAL MEDICAID LIAB	3,859,583.83
		LESS: COB	4,797.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,854,785.97
		ALL OTHER	2,759,670.23
		FEE SCHEDULE-LAB	281,537.77
		INJECTABLE DRUGS	813,577.97

TOTAL NUMBER OF CLAIMS 7,621

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263,892.12	37,608.00
MED/SURG SUPPLY	690,160.47	325.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	501,162.00	27,519.00
CT SCAN	1,964,394.00	231,387.00
PHYSICAL THERAPY	73,041.00	6,781.00
EKG/ECG	154,476.00	2,990.00
IV THERAPY	824,214.00	28,482.00
OPERATING ROOM	1,170,290.00	168,291.00
LABOR/DELIVERY ROOM	42,250.00	0.00
RESPIRATORY SERVICES	43,130.00	10,689.00
ANESTHESIA	157,434.00	0.00
GI SERVICES	350,063.34	75,748.66
EMERGENCY ROOM	1,109,357.00	4,148.00
RECOVERY ROOM	236,966.44	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	769,324.00	10,290.00
OCCUPATIONAL THERAPY	15,560.00	2,677.00
SPEECH PATHOLOGY	5,510.00	4,880.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	227,745.00	4,932.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	480,275.00	32,983.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	66,396.00	8,500.00
ONCOLOGY	22,015.00	0.00
NUCLEAR MEDICINE	319,605.00	11,240.00
AUDIOLOGY	4,055.00	0.00
CARDIOLOGY	662,580.00	97,964.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	449,740.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	222,349.00	44,369.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	51,804.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,601,874.99	226,673.00
MRI SERVICES	592,284.00	18,687.00
PROFESSIONAL FEES	0.00	122.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	315.00
INJECTABLE DRUGS	2,731,528.20	166,087.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	14,936.00
IMPL DEV CHARGE PATIENTS	130,551.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	69.00	0.00

TOTAL ANCILLARY	16,934,095.56	1,238,623.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,934,095.56	1,238,623.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023197003904	07/10/23 - 07/10/23	07/24/23	69.00	0.00	0.00	0.00	20.52
TOTAL				69.00	0.00	0.00	0.00	20.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	130,805.00	ADJUSTMENTS	0.00
COVERED CHARGES	84,645.00	CONTRACTUAL ALLOW	67,463.39
NON-COVERD CHARGES	46,160.00	TOTAL MEDICAID LIAB	17,181.61
		LESS: COB	17,181.61
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,694.00	1,347.00
MED/SURG SUPPLY	6,755.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,086.00	404.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	920.00	230.00
IV THERAPY	1,763.00	0.00
OPERATING ROOM	8,620.00	25,018.00
LABOR/DELIVERY ROOM	750.00	0.00
RESPIRATORY SERVICES	250.00	210.00
ANESTHESIA	3,770.00	0.00
GI SERVICES	7,072.00	0.00
EMERGENCY ROOM	5,756.00	110.00
RECOVERY ROOM	5,369.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	538.00	1,288.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	334.00	374.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,452.00	5,124.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,304.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,808.00	5,616.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,448.00	593.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,233.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,311.00	5,285.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,578.00	561.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	834.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	84,645.00	46,160.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	84,645.00	46,160.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	354,663.00	ADJUSTMENTS	704.88
COVERED CHARGES	332,066.00	CONTRACTUAL ALLOW	317,420.16
NON-COVERD CHARGES	22,597.00	TOTAL MEDICAID LIAB	14,645.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	14,645.84

TOTAL NUMBER OF CLAIMS 187

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,242.00	226.00
MED/SURG SUPPLY	9,259.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,881.00	0.00
CT SCAN	76,544.00	17,535.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,220.00	0.00
IV THERAPY	24,298.00	102.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	210.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	101,435.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	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	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,249.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	114.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	83,187.00	3,898.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,527.00	626.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	332,066.00	22,597.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	332,066.00	22,597.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,047.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,047.00	CONTRACTUAL ALLOW	4,890.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,621.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,032.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,047.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,047.00	0.00

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,051,734.94	ADJUSTMENTS	222,756.79
COVERED CHARGES	5,415,276.79	CONTRACTUAL ALLOW	4,639,342.78
NON-COVERD CHARGES	636,458.15	TOTAL MEDICAID LIAB	775,934.01
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	775,934.01

TOTAL NUMBER OF CLAIMS 143

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,774.00	5,656.00
MED/SURG SUPPLY	596,112.30	80.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,726.00	52,118.00
CT SCAN	64,900.00	3,808.00
PHYSICAL THERAPY	2,276.00	7,980.00
EKG/ECG	5,048.00	1,610.00
IV THERAPY	195,963.00	13,752.00
OPERATING ROOM	752,225.47	231,288.53
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	888.00	125.00
ANESTHESIA	41,817.00	646.00
GI SERVICES	6,573.00	3,672.00
EMERGENCY ROOM	18,404.00	539.00
RECOVERY ROOM	78,291.64	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	140,374.00	0.00
OCCUPATIONAL THERAPY	504.00	1,151.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,370.00	928.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,391.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,156.00	2,436.00
ONCOLOGY	1,258.00	0.00
NUCLEAR MEDICINE	8,933.00	8,291.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	292,222.00	99,166.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	45,703.00	1,099.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,373.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	107,470.00	15,019.00
MRI SERVICES	3,050.00	6,419.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,206,309.38	177,968.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	2,706.00
IMPL DEV CHARGE PATIENTS	724,165.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,415,276.79	636,458.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,415,276.79	636,458.15

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,572.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,520.00	CONTRACTUAL ALLOW	18,098.88
NON-COVERD CHARGES	20,052.00	TOTAL MEDICAID LIAB	5,421.12
		LESS: COB	5,421.12
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	817.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,807.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	82.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	19,042.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,222.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,723.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	233.00	193.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,453.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,520.00	20,052.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,520.00	20,052.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,255,104.15	ADJUSTMENTS	2,534,013.75
COVERED CHARGES	98,497,416.15	CONTRACTUAL ALLOW	81,032,845.29
NON-COVERD CHARGES	757,688.00	TOTAL MEDICAID LIAB	17,464,570.86
		LESS: COB	118,749.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	8,631.00
		REIMBURSEMENT	17,354,452.56

TOTAL NUMBER OF ADMISSIONS 1,774

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,276	0	11,470,306.00	0.00
ROUTINE NURSERY	688	0	2,305,359.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	21,431.00
TOTAL ROUTINE	6,964	0	13,775,665.00	21,431.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,410	0	7,459,895.00	0.00
NICU	6	0	31,248.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	63	0	398,349.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,479	0	7,889,492.00	0.00
TOTAL ACCOMODATIONS	8,443	0	21,665,157.00	21,431.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,652,127.25	0.00
MED/SURG SUPPLY	2,351,374.62	2,574.00
LABORATORY-GENERAL	17,828,861.29	0.00
RADIOLOGY-DIAGNOSTIC	1,009,097.00	0.00
CT SCAN	4,052,020.41	39,096.00
PHYSICAL THERAPY	313,028.00	0.00
EKG/ECG	711,096.00	0.00
IV THERAPY	1,270,946.00	0.00
OPERATING ROOM	10,191,744.00	0.00
LABOR/DELIVERY ROOM	1,662,519.00	4,931.00
RESPIRATORY SERVICES	8,017,834.00	0.00
ANESTHESIA	511,066.00	0.00
GI SERVICES	666,553.00	5,687.00
EMERGENCY ROOM	5,054,475.00	0.00
RECOVERY ROOM	745,361.00	0.00
LABORATORY PATHOLOGIC	520,425.00	0.00
RADIOLOGY THERAPEUTIC	258,195.00	0.00
OCCUPATIONAL THERAPY	121,571.00	0.00
SPEECH PATHOLOGY	203,008.00	0.00
RENAL DIALYSIS	1,259,571.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	41,974.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	72,284.00	0.00
OTHER IMAGING SERVICE	583,294.00	20,996.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	803,104.00	311,427.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	150,720.01	17,274.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,355,893.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	153,163.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,069,157.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	484,992.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	654,268.24	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	334,272.00
IMPL DEV CHARGE PATIENTS	3,062,537.33	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	76,832,259.15	736,257.00
TOTAL ACCOMODATIONS	21,665,157.00	21,431.00
TOTAL CHARGES	98,497,416.15	757,688.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	934,533.87	ADJUSTMENTS	0.00
COVERED CHARGES	930,344.87	CONTRACTUAL ALLOW	743,208.28
NON-COVERD CHARGES	4,189.00	TOTAL MEDICAID LIAB	187,136.59
		LESS: COB	187,829.59
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	693.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	45	0	82,080.00	0.00
ROUTINE NURSERY	59	0	200,570.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	104	0	282,650.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	21,308.00	0.00
NICU	2	0	10,416.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6	0	31,724.00	0.00
TOTAL ACCOMODATIONS	110	0	314,374.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,531.11	0.00
MED/SURG SUPPLY	12,560.14	0.00
LABORATORY-GENERAL	121,094.00	0.00
RADIOLOGY-DIAGNOSTIC	3,403.00	0.00
CT SCAN	17,986.00	0.00
PHYSICAL THERAPY	449.00	0.00
EKG/ECG	2,934.00	0.00
IV THERAPY	11,650.00	0.00
OPERATING ROOM	165,525.00	0.00
LABOR/DELIVERY ROOM	35,275.00	1,142.00
RESPIRATORY SERVICES	55,628.00	0.00
ANESTHESIA	9,218.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	46,012.00	0.00
RECOVERY ROOM	22,501.00	0.00
LABORATORY PATHOLOGIC	2,916.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,598.00	0.00
SPEECH PATHOLOGY	2,111.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,606.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,390.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,386.00	2,694.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,466.00	353.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,997.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,914.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,100.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	720.62	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	615,970.87	4,189.00
TOTAL ACCOMODATIONS	314,374.00	0.00
TOTAL CHARGES	930,344.87	4,189.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,394,328.86	ADJUSTMENTS	554,454.89
COVERED CHARGES	32,083,521.67	CONTRACTUAL ALLOW	28,030,978.76
NON-COVERD CHARGES	9,310,807.19	TOTAL MEDICAID LIAB	4,052,542.91
		LESS: COB	7,962.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,044,580.82
		ALL OTHER	3,161,730.03
		FEE SCHEDULE-LAB	428,004.07
		INJECTABLE DRUGS	454,846.72

TOTAL NUMBER OF CLAIMS 9,846

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	585,230.86	2,407.97
MED/SURG SUPPLY	839,623.78	136,434.45
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957,271.01	7,967.00
CT SCAN	2,655,448.04	660,179.12
PHYSICAL THERAPY	296,440.00	57,332.00
EKG/ECG	414,503.00	14,291.00
IV THERAPY	1,011,808.34	93,382.00
OPERATING ROOM	5,060,107.24	834,574.76
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	261,282.00	148,670.00
ANESTHESIA	333,083.00	745.00
GI SERVICES	498,142.00	170,760.00
EMERGENCY ROOM	6,519,155.02	7,602.00
RECOVERY ROOM	578,326.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	736,130.00	20,082.00
OCCUPATIONAL THERAPY	34,015.00	12,127.00
SPEECH PATHOLOGY	10,005.00	27,468.00
RENAL DIALYSIS	0.00	356,730.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	537.00	12,744.86
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,374,084.00	86,894.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	135,177.00	11,024.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	208,544.00	592,879.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	370,044.00	445,847.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	265,694.00	169,596.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	811,771.45	1,139.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	377,283.00	7,128.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,361,245.82	467,407.50
MRI SERVICES	150,460.00	194,424.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	471.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,338.77
INJECTABLE DRUGS	1,178,911.19	2,793,071.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	376,056.00
IMPL DEV CHARGE PATIENTS	59,199.92	1,587,942.85
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,091.00

TOTAL ANCILLARY	32,083,521.67	9,310,807.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,083,521.67	9,310,807.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022242034263	08/10/22 - 08/10/22	09/05/22	0.00	4,091.00	0.00	0.00	0.00
TOTAL				0.00	4,091.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	893,651.50	ADJUSTMENTS	0.00
COVERED CHARGES	468,316.09	CONTRACTUAL ALLOW	413,959.80
NON-COVERD CHARGES	425,335.41	TOTAL MEDICAID LIAB	54,356.29
		LESS: COB	54,356.29
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,812.65	744.64
MED/SURG SUPPLY	6,630.27	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,134.00	161.00
CT SCAN	12,563.00	54,581.00
PHYSICAL THERAPY	4,500.00	0.00
EKG/ECG	4,610.00	0.00
IV THERAPY	12,802.00	194.00
OPERATING ROOM	156,634.00	38,784.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,549.00	15,360.00
ANESTHESIA	11,130.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	101,777.00	0.00
RECOVERY ROOM	21,227.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,450.00	0.00
SPEECH PATHOLOGY	712.00	459.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	143.00	143.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,178.00	1,132.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,853.00	1,109.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	14,133.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,930.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,527.00	1,199.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	69,242.00	8,796.50
MRI SERVICES	3,368.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,275.95	6,954.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	10,446.00
IMPL DEV CHARGE PATIENTS	267.47	271,138.94
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	468,316.09	425,335.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	468,316.09	425,335.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,750,914.90	ADJUSTMENTS	335.65
COVERED CHARGES	1,686,110.91	CONTRACTUAL ALLOW	1,651,538.95
NON-COVERD CHARGES	64,803.99	TOTAL MEDICAID LIAB	34,571.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	34,571.96

TOTAL NUMBER OF CLAIMS 516

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,167.14	83.20
MED/SURG SUPPLY	820.00	249.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,149.00	698.00
CT SCAN	253,623.00	17,620.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	19,362.00	461.00
IV THERAPY	72,737.00	13,009.00
OPERATING ROOM	4,687.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,114.00	1,282.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	934,332.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,297.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,240.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	663.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,336.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	253,635.00	12,258.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,948.76	8,697.19
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	10,446.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,686,110.91	64,803.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,686,110.91	64,803.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,496.64	ADJUSTMENTS	0.00
COVERED CHARGES	34,221.04	CONTRACTUAL ALLOW	33,415.48
NON-COVERD CHARGES	7,275.60	TOTAL MEDICAID LIAB	805.56
		LESS: COB	805.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	297.04	166.40
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,264.00	0.00
CT SCAN	0.00	4,473.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,628.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,502.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,281.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,380.00	1,194.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	150.00	161.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,221.04	7,275.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,221.04	7,275.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,610,024.27	ADJUSTMENTS	17,299.05
COVERED CHARGES	4,906,936.48	CONTRACTUAL ALLOW	4,508,458.94
NON-COVERD CHARGES	703,087.79	TOTAL MEDICAID LIAB	398,477.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	398,477.54

TOTAL NUMBER OF CLAIMS 69

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,770.80	0.00
MED/SURG SUPPLY	155,876.84	13,239.71
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,023.00	322.00
CT SCAN	0.00	7,168.00
PHYSICAL THERAPY	0.00	7,639.00
EKG/ECG	3,227.00	0.00
IV THERAPY	20,752.00	0.00
OPERATING ROOM	1,125,170.34	31,780.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,263.00	1,650.00
ANESTHESIA	56,901.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,220.00	0.00
RECOVERY ROOM	103,382.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	34,938.00	0.00
OCCUPATIONAL THERAPY	0.00	817.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	210.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	36,142.00	0.00
OTHER IMAGING SERVICE	2,506.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,488.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	7,076.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	179,067.00	4,623.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,496.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,633.00	11,635.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,365,845.77	135,817.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	679,233.83	481,109.51
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,906,936.48	703,087.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,906,936.48	703,087.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,713,360.48	ADJUSTMENTS	31,234.39
COVERED CHARGES	1,703,234.48	CONTRACTUAL ALLOW	1,247,827.39
NON-COVERD CHARGES	10,126.00	TOTAL MEDICAID LIAB	455,407.09
		LESS: COB	7,076.70
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	23,000.00
		REIMBURSEMENT	471,330.39

TOTAL NUMBER OF ADMISSIONS 98

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	200	0	347,202.00	0.00
ROUTINE NURSERY	39	0	48,024.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	239	0	395,226.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	29	0	75,013.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	29	0	75,013.00	0.00
TOTAL ACCOMODATIONS	268	0	470,239.00	0.00

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,424.68	0.00
MED/SURG SUPPLY	225,138.20	0.00
LABORATORY-GENERAL	245,207.00	0.00
RADIOLOGY-DIAGNOSTIC	27,127.00	0.00
CT SCAN	66,663.00	2,384.00
PHYSICAL THERAPY	9,965.00	0.00
EKG/ECG	10,000.00	0.00
IV THERAPY	17,937.00	0.00
OPERATING ROOM	113,631.00	0.00
LABOR/DELIVERY ROOM	86,334.00	0.00
RESPIRATORY SERVICES	65,402.00	0.00
ANESTHESIA	14,057.00	0.00
GI SERVICES	11,260.00	0.00
EMERGENCY ROOM	31,501.00	0.00
RECOVERY ROOM	9,447.00	0.00
LABORATORY PATHOLOGIC	3,052.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	911.00	0.00
SPEECH PATHOLOGY	1,777.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,675.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,733.00	7,742.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,844.00	0.00
AUDIOLOGY	8,200.00	0.00
CARDIOLOGY	1,071.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,489.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,409.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,300.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	81,337.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	45,103.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,232,995.48	10,126.00
TOTAL ACCOMODATIONS	470,239.00	0.00
TOTAL CHARGES	1,703,234.48	10,126.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,792,732.22	ADJUSTMENTS	58,877.83
COVERED CHARGES	1,673,035.00	CONTRACTUAL ALLOW	1,252,340.83
NON-COVERD CHARGES	119,697.22	TOTAL MEDICAID LIAB	420,694.17
		LESS: COB	393.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	420,300.96
		ALL OTHER	378,557.76
		FEE SCHEDULE-LAB	40,143.87
		INJECTABLE DRUGS	1,599.33

TOTAL NUMBER OF CLAIMS 908

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,097.67	166.54
MED/SURG SUPPLY	99,857.97	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,394.00	2,177.00
CT SCAN	233,039.00	1,703.00
PHYSICAL THERAPY	40,038.00	2,178.00
EKG/ECG	25,712.00	1,876.00
IV THERAPY	66,345.00	2,560.00
OPERATING ROOM	81,579.97	11,688.03
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	123,389.50	56,509.00
ANESTHESIA	1,897.00	0.00
GI SERVICES	25,693.00	828.00
EMERGENCY ROOM	148,429.00	456.00
RECOVERY ROOM	5,357.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,571.00	237.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	144.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	21,390.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,333.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,293.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	61,446.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,285.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	54,899.00	701.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	346,185.00	2,502.00
MRI SERVICES	56,861.00	2,644.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30,639.89	5,472.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	16,159.00	27,999.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,673,035.00	119,697.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,673,035.00	119,697.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,037.63	ADJUSTMENTS	0.00
COVERED CHARGES	19,737.38	CONTRACTUAL ALLOW	14,817.17
NON-COVERD CHARGES	14,300.25	TOTAL MEDICAID LIAB	4,920.21
		LESS: COB	4,920.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	737.61	539.42
MED/SURG SUPPLY	1,774.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,212.00	0.00
CT SCAN	0.00	1,703.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	332.00	176.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,634.00	10,232.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	872.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,118.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	1,296.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,700.00	125.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	357.77	228.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,737.38	14,300.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,737.38	14,300.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,916.24	ADJUSTMENTS	630.00
COVERED CHARGES	114,762.07	CONTRACTUAL ALLOW	106,931.07
NON-COVERD CHARGES	1,154.17	TOTAL MEDICAID LIAB	7,831.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,831.00

TOTAL NUMBER OF CLAIMS 113

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,028.75	0.00
MED/SURG SUPPLY	2,983.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,065.00	0.00
CT SCAN	18,038.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,277.00	0.00
IV THERAPY	9,943.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,274.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	398.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,102.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,332.00	534.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,321.32	620.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	114,762.07	1,154.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	114,762.07	1,154.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	484,199.68	ADJUSTMENTS	25,153.41
COVERED CHARGES	459,149.58	CONTRACTUAL ALLOW	403,812.03
NON-COVERD CHARGES	25,050.10	TOTAL MEDICAID LIAB	55,337.55
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	55,337.55

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,261.82	0.00
MED/SURG SUPPLY	231,284.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,956.00	3,179.00
CT SCAN	5,443.00	0.00
PHYSICAL THERAPY	0.00	252.00
EKG/ECG	201.00	104.00
IV THERAPY	744.00	167.00
OPERATING ROOM	34,031.22	15,329.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	630.00	78.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,159.00	152.00
RECOVERY ROOM	4,708.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,320.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,759.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,351.26	5,788.32
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	152,301.28	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	459,149.58	25,050.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	459,149.58	25,050.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,170.36	ADJUSTMENTS	0.00
COVERED CHARGES	19,529.01	CONTRACTUAL ALLOW	14,498.32
NON-COVERD CHARGES	2,641.35	TOTAL MEDICAID LIAB	5,030.69
		LESS: COB	5,030.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,173.34	79.91	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	212.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,505.00	1,703.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,117.00	20.00
EKG/ECG	201.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	345.00	783.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,862.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41.67	55.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	72.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,529.01	2,641.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,529.01	2,641.35

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,311,868.46	ADJUSTMENTS	200,699.70
COVERED CHARGES	6,260,818.30	CONTRACTUAL ALLOW	4,408,844.45
NON-COVERD CHARGES	51,050.16	TOTAL MEDICAID LIAB	1,851,973.85
		LESS: COB	30,589.87
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,821,383.98

TOTAL NUMBER OF ADMISSIONS 281

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	225	0	224,025.00	0.00
ROUTINE NURSERY	97	0	107,950.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.06
TOTAL ROUTINE	322	0	331,975.00	0.06
SPECIAL CARE SERVICES				
CCU	513	0	837,729.00	0.00
ICU	212	0	606,016.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	725	0	1,443,745.00	0.00
TOTAL ACCOMODATIONS	1,047	0	1,775,720.00	0.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	818,329.36	0.00
MED/SURG SUPPLY	104,281.13	0.00
LABORATORY-GENERAL	847,142.61	0.00
RADIOLOGY-DIAGNOSTIC	57,444.35	0.00
CT SCAN	473,435.80	0.00
PHYSICAL THERAPY	27,097.45	0.00
EKG/ECG	49,950.05	0.00
IV THERAPY	123,800.45	0.00
OPERATING ROOM	206,899.50	0.00
LABOR/DELIVERY ROOM	125,677.85	0.00
RESPIRATORY SERVICES	402,274.60	0.00
ANESTHESIA	91,788.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	345,691.45	0.00
RECOVERY ROOM	39,894.50	0.00
LABORATORY PATHOLOGIC	9,229.50	0.00
RADIOLOGY THERAPEUTIC	15,433.00	0.00
OCCUPATIONAL THERAPY	14,687.45	0.00
SPEECH PATHOLOGY	20,401.30	0.00
RENAL DIALYSIS	22,560.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,275.70	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	36,442.05	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	54,823.90	33,866.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,127.33	10,018.20
AUDIOLOGY	2,088.45	0.00
CARDIOLOGY	159,930.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	72,089.10	5,160.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	28,047.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	953.60	0.00
OTHER THERAPEUTIC SVC	78,099.25	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	15,708.52	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,005.50
INJECTABLE DRUGS	110,654.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	109,838.85	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,485,098.30	51,050.10
TOTAL ACCOMODATIONS	1,775,720.00	0.06
TOTAL CHARGES	6,260,818.30	51,050.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,496.50	ADJUSTMENTS	0.00
COVERED CHARGES	30,348.55	CONTRACTUAL ALLOW	19,309.25
NON-COVERD CHARGES	147.95	TOTAL MEDICAID LIAB	11,039.30
		LESS: COB	11,039.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	0	0	0.00	0.00
SPECIAL CARE SERVICES				
CCU	5	0	8,165.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	8,165.00	0.00
TOTAL ACCOMODATIONS	5	0	8,165.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,787.85	0.00
MED/SURG SUPPLY	28.35	0.00
LABORATORY-GENERAL	4,553.50	0.00
RADIOLOGY-DIAGNOSTIC	285.80	0.00
CT SCAN	2,636.85	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	430.50	0.00
OPERATING ROOM	1,497.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	115.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,394.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,092.30	147.95

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	386.50	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	975.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,183.55	147.95
TOTAL ACCOMODATIONS	8,165.00	0.00
TOTAL CHARGES	30,348.55	147.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,649,759.32	ADJUSTMENTS	270,087.17
COVERED CHARGES	4,852,304.70	CONTRACTUAL ALLOW	3,803,733.60
NON-COVERD CHARGES	797,454.62	TOTAL MEDICAID LIAB	1,048,571.10
		LESS: COB	4,561.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,044,009.57
		ALL OTHER	905,293.69
		FEE SCHEDULE-LAB	129,649.34
		INJECTABLE DRUGS	9,066.54

TOTAL NUMBER OF CLAIMS 2,180

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,335.65	0.00
MED/SURG SUPPLY	85,586.70	1,525.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	148,401.45	6,142.35
CT SCAN	887,797.40	68,487.55
PHYSICAL THERAPY	72,094.95	8,617.50
EKG/ECG	49,334.15	8,980.60
IV THERAPY	72,938.50	19,487.70
OPERATING ROOM	93,446.99	15,854.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	22,198.80	8,414.75
ANESTHESIA	54,767.80	0.00
GI SERVICES	87,890.82	9,981.13
EMERGENCY ROOM	1,449,443.20	4,233.60
RECOVERY ROOM	75,599.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	126,279.05	422,018.85
OCCUPATIONAL THERAPY	620.30	534.25
SPEECH PATHOLOGY	2,497.15	395.55
RENAL DIALYSIS	0.00	705.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,775.55	186.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	160,064.40	9,096.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	15,571.90	1,186.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	37,406.75	12,971.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,839.40	26,502.25
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,024.35	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	78,248.30	1,881.90

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	27,189.55	125.45
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	159,174.95	45,887.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	769,774.19	22,284.33
MRI SERVICES	69,797.25	4,437.60
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	103,367.55	97,515.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	20,838.05	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,852,304.70	797,454.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,852,304.70	797,454.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,905.40	ADJUSTMENTS	0.00
COVERED CHARGES	35,442.75	CONTRACTUAL ALLOW	28,257.53
NON-COVERD CHARGES	11,462.65	TOTAL MEDICAID LIAB	7,185.22
		LESS: COB	7,185.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376.40	0.00
MED/SURG SUPPLY	2,320.68	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,760.55	0.00
CT SCAN	3,911.55	5,197.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	369.45	0.00
OPERATING ROOM	0.00	3,920.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,487.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,231.40	1,018.50
RECOVERY ROOM	1,377.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	938.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,020.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,162.30	387.90
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,648.90	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	776.82	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,442.75	11,462.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,442.75	11,462.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	347,677.20	ADJUSTMENTS	313.28
COVERED CHARGES	339,512.15	CONTRACTUAL ALLOW	318,209.11
NON-COVERD CHARGES	8,165.05	TOTAL MEDICAID LIAB	21,303.04
		LESS: COB	20.82
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,282.22

TOTAL NUMBER OF CLAIMS 272

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,325.90	0.00
MED/SURG SUPPLY	55.40	25.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,219.60	0.00
CT SCAN	11,032.00	5,677.15
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,548.40	236.25
IV THERAPY	2,852.25	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	218,389.65	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	639.10	147.95

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	510.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	23,249.85	425.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,911.60	1,511.30
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,778.25	142.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	339,512.15	8,165.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	339,512.15	8,165.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,057.70	ADJUSTMENTS	0.00
COVERED CHARGES	7,005.55	CONTRACTUAL ALLOW	6,613.95
NON-COVERD CHARGES	52.15	TOTAL MEDICAID LIAB	391.60
		LESS: COB	391.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	473.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	142.90	0.00	OTHER THERAPEUTIC SVC	529.65	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,292.70	52.15
EKG/ECG	147.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	130.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,096.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	191.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,005.55	52.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,005.55	52.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	264,751.03	ADJUSTMENTS	5,102.40
COVERED CHARGES	257,421.39	CONTRACTUAL ALLOW	231,909.12
NON-COVERD CHARGES	7,329.64	TOTAL MEDICAID LIAB	25,512.27
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,512.27

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,193.30	0.00
MED/SURG SUPPLY	27,662.99	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	788.55	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	295.70	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	30,086.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	15,014.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	15,017.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,892.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,080.70
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,418.60	17.14
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,028.45	6,231.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	158,023.20	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	257,421.39	7,329.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	257,421.39	7,329.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NAVICENT HEALTH BALDWIN INC
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,712.67	ADJUSTMENTS	0.00
COVERED CHARGES	43,712.67	CONTRACTUAL ALLOW	13,072.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	30,639.87
		LESS: COB	1,986.51
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	28,653.36

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17	0	8,245.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	0	8,245.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	17	0	8,245.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,108.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,345.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,235.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,940.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,474.40	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	580.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,242.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,324.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,656.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,467.67	0.00
TOTAL ACCOMODATIONS	8,245.00	0.00
TOTAL CHARGES	43,712.67	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,865.09	ADJUSTMENTS	59,185.10
COVERED CHARGES	434,484.22	CONTRACTUAL ALLOW	198,441.71
NON-COVERD CHARGES	38,380.87	TOTAL MEDICAID LIAB	236,042.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	236,042.51
		ALL OTHER	212,159.79
		FEE SCHEDULE-LAB	23,409.38
		INJECTABLE DRUGS	473.34

TOTAL NUMBER OF CLAIMS 480

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,536.50	11,311.02
MED/SURG SUPPLY	13,729.03	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,017.00	2,449.50
CT SCAN	76,951.80	15,522.40
PHYSICAL THERAPY	19,844.45	0.00
EKG/ECG	8,240.00	250.00
IV THERAPY	22,692.00	46.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,698.80	259.90
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	91,047.10	1,298.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	51.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	749.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	780.85	1,023.95
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,685.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,599.72	260.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	157,983.07	2,231.85
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,554.00	3,676.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	375.00	0.00

TOTAL ANCILLARY	434,484.22	38,380.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	434,484.22	38,380.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022202075851	06/27/22 - 06/27/22	07/25/22	125.00	0.00	0.00	0.00	20.52
780	2022320040308	11/09/22 - 11/09/22	11/21/22	125.00	0.00	0.00	0.00	20.52
780	5923041000161	01/25/23 - 01/25/23	02/13/23	125.00	0.00	0.00	0.00	20.52
TOTAL				375.00	0.00	0.00	0.00	61.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,677.70	ADJUSTMENTS	140.00
COVERED CHARGES	11,020.70	CONTRACTUAL ALLOW	9,060.70
NON-COVERD CHARGES	657.00	TOTAL MEDICAID LIAB	1,960.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,960.00

TOTAL NUMBER OF CLAIMS 28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.50	296.00
MED/SURG SUPPLY	114.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	922.20	0.00
CT SCAN	1,627.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	250.00	0.00
IV THERAPY	430.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	44.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,116.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,100.80	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	310.00	361.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,020.70	657.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,020.70	657.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,899.00	ADJUSTMENTS	0.00
COVERED CHARGES	24,899.00	CONTRACTUAL ALLOW	15,986.63
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,912.37
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,912.37

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4	0	3,950.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	3,950.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	3,950.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,585.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,306.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,424.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	372.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,107.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	230.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,704.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,221.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,949.00	0.00
TOTAL ACCOMODATIONS	3,950.00	0.00
TOTAL CHARGES	24,899.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,054,591.00	ADJUSTMENTS	31,348.80
COVERED CHARGES	1,009,828.00	CONTRACTUAL ALLOW	668,592.58
NON-COVERD CHARGES	44,763.00	TOTAL MEDICAID LIAB	341,235.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	341,235.42
		ALL OTHER	314,002.35
		FEE SCHEDULE-LAB	26,224.56
		INJECTABLE DRUGS	1,008.51

TOTAL NUMBER OF CLAIMS 1,270

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,495.00	436.00
MED/SURG SUPPLY	8,564.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,112.00	1,557.00
CT SCAN	150,095.00	22,100.00
PHYSICAL THERAPY	89,157.00	3,578.00
EKG/ECG	9,200.00	230.00
IV THERAPY	57,278.00	844.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,345.00	630.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	284,322.00	232.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	27,413.00	1,732.00
SPEECH PATHOLOGY	8,055.00	2,066.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	512.00	384.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,379.00	1,032.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,395.00	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	216,240.00	8,584.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,266.00	1,358.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,009,828.00	44,763.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,009,828.00	44,763.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,624.00	ADJUSTMENTS	0.00
COVERED CHARGES	27,475.00	CONTRACTUAL ALLOW	24,605.00
NON-COVERD CHARGES	149.00	TOTAL MEDICAID LIAB	2,870.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,870.00

TOTAL NUMBER OF CLAIMS 41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124.00	143.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	123.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,808.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,897.00	0.00
EKG/ECG	230.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	816.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	305.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,033.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	139.00	6.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,475.00	149.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,475.00	149.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,255.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,853.00	CONTRACTUAL ALLOW	1,713.00
NON-COVERD CHARGES	402.00	TOTAL MEDICAID LIAB	140.00
		LESS: COB	140.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	33.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	157.00	363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	300.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,393.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	6.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,853.00	402.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,853.00	402.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,196.00	ADJUSTMENTS	5,440.72
COVERED CHARGES	156,581.00	CONTRACTUAL ALLOW	124,983.52
NON-COVERD CHARGES	5,615.00	TOTAL MEDICAID LIAB	31,597.48
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	31,597.48

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,661.00	105.00
MED/SURG SUPPLY	1,067.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,122.00	667.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	230.00
IV THERAPY	11,504.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	264.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	972.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,428.00	1,428.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,848.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,931.00	3,005.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	784.00	180.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	156,581.00	5,615.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	156,581.00	5,615.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,201,111.81	ADJUSTMENTS	26,480.62
COVERED CHARGES	27,889,962.88	CONTRACTUAL ALLOW	23,696,974.00
NON-COVERD CHARGES	311,148.93	TOTAL MEDICAID LIAB	4,192,988.88
		LESS: COB	37,729.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,347.00
		REIMBURSEMENT	4,159,606.31

TOTAL NUMBER OF ADMISSIONS 542

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	519	0	813,382.50	0.00
ROUTINE NURSERY	221	0	378,087.65	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	740	0	1,191,470.15	0.00
SPECIAL CARE SERVICES				
CCU	180	0	481,332.50	0.00
ICU	1,470	0	3,239,760.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,650	0	3,721,092.50	0.00
TOTAL ACCOMODATIONS	2,390	0	4,912,562.65	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,166,179.00	0.00
MED/SURG SUPPLY	1,120,000.10	25,452.60
LABORATORY-GENERAL	3,221,958.19	68,582.51
RADIOLOGY-DIAGNOSTIC	485,159.53	3,112.75
CT SCAN	1,678,167.50	8,062.55
PHYSICAL THERAPY	264,659.80	6,453.00
EKG/ECG	114,196.65	927.90
IV THERAPY	816.50	0.00
OPERATING ROOM	2,939,587.12	0.00
LABOR/DELIVERY ROOM	219,472.25	267.75
RESPIRATORY SERVICES	1,196,255.06	41,367.62
ANESTHESIA	471,597.45	0.00
GI SERVICES	237,343.95	0.00
EMERGENCY ROOM	2,190,320.95	259.35
RECOVERY ROOM	159,682.60	0.00
LABORATORY PATHOLOGIC	92,739.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,946.00	0.00
SPEECH PATHOLOGY	28,961.60	0.00
RENAL DIALYSIS	148,518.50	16,933.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,743.25	705.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	82,992.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	133,811.85	61,665.55
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,162.55	2,748.65
AUDIOLOGY	45,496.50	0.00
CARDIOLOGY	1,542,628.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	25,070.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	89,660.05	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	81,963.65	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,627.75	200.50
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	296,013.70	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65,628.56	74,409.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	772,200.57	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	35,838.35	0.00

TOTAL ANCILLARY	22,977,400.23	311,148.93
TOTAL ACCOMODATIONS	4,912,562.65	0.00
TOTAL CHARGES	27,889,962.88	311,148.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023009014484	12/26/22 - 12/29/22	01/16/23	2,003.40	0.00	0.00	0.00	0.00
614	2023017045046	12/20/22 - 12/29/22	01/23/23	2,977.80	0.00	0.00	0.00	0.00
615	2023025036999	01/12/23 - 01/17/23	01/30/23	4,077.00	0.00	0.00	0.00	0.00
615	2023032049300	12/31/22 - 01/16/23	02/06/23	3,882.90	0.00	0.00	0.00	0.00
614	2023117052515	04/14/23 - 04/20/23	05/01/23	2,103.50	0.00	0.00	0.00	0.00
614	2023129036053	04/26/23 - 05/01/23	05/15/23	2,103.50	0.00	0.00	0.00	0.00
614	2023151032177	05/13/23 - 05/19/23	06/05/23	2,103.50	0.00	0.00	0.00	0.00
615	2023193058396	06/27/23 - 06/30/23	07/17/23	4,077.00	0.00	0.00	0.00	0.00
614	2223193007029	05/28/23 - 06/09/23	07/17/23	2,103.50	0.00	0.00	0.00	0.00
614	2023212010662	07/10/23 - 07/17/23	08/07/23	2,122.25	0.00	0.00	0.00	0.00
614	2223243006191	06/20/23 - 06/28/23	09/04/23	2,103.50	0.00	0.00	0.00	0.00
615	2023243053414	08/16/23 - 08/25/23	09/04/23	4,077.00	0.00	0.00	0.00	0.00
614	2023285038657	09/12/23 - 10/09/23	10/16/23	2,103.50	0.00	0.00	0.00	0.00
TOTAL				35,838.35	0.00	0.00	0.00	0.00

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	348,156.19	ADJUSTMENTS	0.00
COVERED CHARGES	348,156.19	CONTRACTUAL ALLOW	287,878.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	60,278.05
		LESS: COB	60,278.05
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	31	0	48,063.75	0.00
ROUTINE NURSERY	2	0	2,937.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	51,000.75	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	33	0	51,000.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,158.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,279.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,335.01	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,518.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,500.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	247.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,196.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,921.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,002.40	0.00	INJECTABLE DRUGS	80.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	121.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	381.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	589.75	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	822.35	0.00			

TOTAL ANCILLARY	297,155.44	0.00
TOTAL ACCOMODATIONS	51,000.75	0.00
TOTAL CHARGES	348,156.19	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,849,908.30	ADJUSTMENTS	53,547.02
COVERED CHARGES	18,399,547.63	CONTRACTUAL ALLOW	17,344,488.84
NON-COVERD CHARGES	3,450,360.67	TOTAL MEDICAID LIAB	1,055,058.79
		LESS: COB	6,987.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,048,071.52
		ALL OTHER	938,653.82
		FEE SCHEDULE-LAB	96,435.50
		INJECTABLE DRUGS	12,982.20

TOTAL NUMBER OF CLAIMS 2,980

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345,116.15	281.00
MED/SURG SUPPLY	198,517.55	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	673,891.83	45,518.57
CT SCAN	2,406,116.55	786,494.80
PHYSICAL THERAPY	0.00	11,834.75
EKG/ECG	93,169.05	10,452.75
IV THERAPY	329,740.90	82,074.25
OPERATING ROOM	2,230,748.87	558,545.24
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	90,514.91	32,610.83
ANESTHESIA	498,853.45	23,722.55
GI SERVICES	432,927.33	45,391.67
EMERGENCY ROOM	5,165,724.90	449,788.20
RECOVERY ROOM	357,336.56	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,510.05	0.00
OCCUPATIONAL THERAPY	0.00	1,074.00
SPEECH PATHOLOGY	2,355.00	4,329.60
RENAL DIALYSIS	0.00	5,507.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	41,041.60	2,574.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	440,504.70	86,735.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	38,269.55	596.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	108,246.90	30,762.75
AUDIOLOGY	589.75	0.00
CARDIOLOGY	1,202,730.80	111,508.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,090.55	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	205,761.50	26,268.03

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	367,639.95	7,558.70
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	988.40
OTHER THERAPEUTIC SVC	0.00	11,067.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,128,770.43	103,412.69
MRI SERVICES	197,017.15	22,016.80
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	716,434.80	105,368.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	28,440.80	878,920.80
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	94,486.05	4,955.75

TOTAL ANCILLARY	18,399,547.63	3,450,360.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,399,547.63	3,450,360.67

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022327053638	11/18/22 - 11/18/22	11/28/22	2,021.25	0.00	0.00	0.00	123.02
614	2022327053642	11/18/22 - 11/18/22	11/28/22	10,162.95	0.00	0.00	0.00	618.54
614	2022327053642	11/18/22 - 11/18/22	11/28/22	10,162.95	0.00	0.00	0.00	618.54
614	2023073049955	03/09/23 - 03/09/23	03/20/23	2,101.25	0.00	0.00	0.00	127.89
614	2023073050098	03/08/23 - 03/08/23	03/20/23	10,671.00	0.00	0.00	0.00	649.46
614	2223081009812	03/10/23 - 03/10/23	03/27/23	2,103.50	0.00	0.00	0.00	128.02
614	2023093015877	03/28/23 - 03/28/23	04/10/23	0.00	4,955.75	0.00	0.00	0.00
614	2023103057374	03/23/23 - 03/23/23	04/17/23	2,828.00	0.00	0.00	0.00	172.12
614	2023104052612	04/10/23 - 04/10/23	04/17/23	10,671.00	0.00	0.00	0.00	649.46
614	2023115040276	04/20/23 - 04/20/23	05/01/23	10,671.00	0.00	0.00	0.00	649.46
614	2023122038332	04/26/23 - 04/26/23	05/08/23	3,160.75	0.00	0.00	0.00	192.37
614	2023135015008	05/11/23 - 05/11/23	05/22/23	2,101.25	0.00	0.00	0.00	127.89
614	2023150051169	05/17/23 - 05/17/23	06/05/23	2,122.25	0.00	0.00	0.00	129.17
614	2023198011217	07/11/23 - 07/11/23	07/24/23	10,671.00	0.00	0.00	0.00	649.46
615	2023262033873	09/15/23 - 09/15/23	09/25/23	4,077.00	0.00	0.00	0.00	245.40
614	2023262033883	09/14/23 - 09/14/23	09/25/23	4,955.75	0.00	0.00	0.00	298.29
614	2023275019347	09/27/23 - 09/27/23	10/09/23	2,122.25	0.00	0.00	0.00	127.74
615	2023311055338	11/28/22 - 11/28/22	11/13/23	3,882.90	0.00	0.00	0.00	233.72
TOTAL				94,486.05	4,955.75	0.00	0.00	5,740.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	455,994.75	ADJUSTMENTS	0.00
COVERED CHARGES	374,606.98	CONTRACTUAL ALLOW	353,982.97
NON-COVERD CHARGES	81,387.77	TOTAL MEDICAID LIAB	20,624.01
		LESS: COB	20,624.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,274.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,308.18	1,185.50
CT SCAN	9,063.75	20,248.75
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,521.25	234.75
IV THERAPY	4,532.70	592.20
OPERATING ROOM	0.00	22,846.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,857.95	0.00
ANESTHESIA	4,851.30	0.00
GI SERVICES	0.00	12,739.50
EMERGENCY ROOM	193,954.70	0.00
RECOVERY ROOM	5,453.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,586.75	144.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,536.50	10,105.85
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,763.75	931.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	6,193.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,293.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,687.55	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	76,670.95	2,551.62
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,250.85	3,612.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	374,606.98	81,387.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	374,606.98	81,387.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,937,202.82	ADJUSTMENTS	537.04
COVERED CHARGES	1,812,501.10	CONTRACTUAL ALLOW	1,788,334.30
NON-COVERD CHARGES	124,701.72	TOTAL MEDICAID LIAB	24,166.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	24,166.80

TOTAL NUMBER OF CLAIMS 360

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,979.29	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,810.65	4,093.06
CT SCAN	317,984.25	89,577.55
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,365.95	0.00
IV THERAPY	54,132.65	8,110.30
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	586.95	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,002,116.15	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 SERVICE	24,101.45	12,655.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,682.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	27,585.75	1,481.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	185,589.19	6,533.95
MRI SERVICES	20,289.25	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	77,277.32	2,249.46
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,812,501.10	124,701.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,812,501.10	124,701.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,092.05	ADJUSTMENTS	0.00
COVERED CHARGES	83,502.75	CONTRACTUAL ALLOW	81,958.76
NON-COVERD CHARGES	7,589.30	TOTAL MEDICAID LIAB	1,543.99
		LESS: COB	1,543.99
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.05	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,107.40	1,112.00
CT SCAN	13,597.50	5,389.65
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,004.50	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	63,184.05	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	979.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,700.25	18.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,829.00	90.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	83,502.75	7,589.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,502.75	7,589.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,440,813.81	ADJUSTMENTS	5,261.41
COVERED CHARGES	2,440,813.81	CONTRACTUAL ALLOW	2,170,654.52
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	270,159.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	270,159.29

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	30	0	18,000.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	30	0	18,000.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	3,600.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	3,600.00	0.00
TOTAL ACCOMODATIONS	33	0	21,600.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,252.55	0.00
MED/SURG SUPPLY	28,108.66	0.00
LABORATORY-GENERAL	23,676.99	0.00
RADIOLOGY-DIAGNOSTIC	10,846.49	0.00
CT SCAN	6,301.00	0.00
PHYSICAL THERAPY	8,821.31	0.00
EKG/ECG	3,589.50	0.00
IV THERAPY	8,031.38	0.00
OPERATING ROOM	1,137,840.76	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,905.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,226.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,958.18	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,835.68	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	67,092.08	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,140.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	940.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,297.98	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,032,349.75	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,419,213.81	0.00
TOTAL ACCOMODATIONS	21,600.00	0.00
TOTAL CHARGES	2,440,813.81	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,412,883.41	ADJUSTMENTS	90,181.86
COVERED CHARGES	2,090,015.21	CONTRACTUAL ALLOW	1,692,994.22
NON-COVERD CHARGES	322,868.20	TOTAL MEDICAID LIAB	397,020.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	397,020.99
		ALL OTHER	381,172.93
		FEE SCHEDULE-LAB	14,870.39
		INJECTABLE DRUGS	977.67

TOTAL NUMBER OF CLAIMS 789

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,693.38	4,604.90
MED/SURG SUPPLY	13,823.49	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,363.27	3,146.65
CT SCAN	138,369.70	23,208.06
PHYSICAL THERAPY	0.00	451.95
EKG/ECG	29,421.07	4,094.00
IV THERAPY	101,687.11	25,358.86
OPERATING ROOM	132,701.89	46,203.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	39,601.11	20,821.04
ANESTHESIA	767.75	0.00
GI SERVICES	12,352.46	11,219.04
EMERGENCY ROOM	950,502.26	32,038.57
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	353.25
SPEECH PATHOLOGY	0.00	271.90
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,115.08	836.31
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	43,922.49	2,721.18
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	83,618.08	36,513.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	163,807.71	32,753.36
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,075.81	835.36

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,683.63	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	222.15
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	172,516.14	17,340.66
MRI SERVICES	17,670.82	3,433.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24,321.96	2,596.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	53,844.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,090,015.21	322,868.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,090,015.21	322,868.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,931.94	ADJUSTMENTS	0.00
COVERED CHARGES	3,898.41	CONTRACTUAL ALLOW	3,229.54
NON-COVERD CHARGES	33.53	TOTAL MEDICAID LIAB	668.87
		LESS: COB	668.87
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	415.18	33.53
EKG/ECG	271.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	298.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,879.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,898.41	33.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,898.41	33.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	370,679.18	ADJUSTMENTS	861.52
COVERED CHARGES	363,478.44	CONTRACTUAL ALLOW	353,218.52
NON-COVERD CHARGES	7,200.74	TOTAL MEDICAID LIAB	10,259.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,259.92

TOTAL NUMBER OF CLAIMS 131

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	739.30	573.95
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,407.42	0.00
CT SCAN	22,285.94	4,471.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,608.75	0.00
IV THERAPY	17,858.78	298.89
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	854.27	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	281,137.07	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 SERVICE	535.36	444.76
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21,306.59	1,214.44
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,744.96	197.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	363,478.44	7,200.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	363,478.44	7,200.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,777,428.20	ADJUSTMENTS	72,759.84
COVERED CHARGES	2,049,475.98	CONTRACTUAL ALLOW	1,922,146.38
NON-COVERD CHARGES	727,952.22	TOTAL MEDICAID LIAB	127,329.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	127,329.60

TOTAL NUMBER OF CLAIMS 21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,412.16	4,336.25
MED/SURG SUPPLY	1,122,912.92	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,005.73	2,094.20
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	2,222.83
EKG/ECG	1,279.25	321.75
IV THERAPY	3,618.51	765.09
OPERATING ROOM	750,498.23	101,446.83
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	23,178.27	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,565.60	256.97
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,470.71
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,753.52	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	99,289.10	438,414.18
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	720.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,420.67	2,561.46
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,822.02	1,798.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	172,263.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,049,475.98	727,952.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,049,475.98	727,952.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE HOSPITAL COMPANY
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	142,574,348.38	ADJUSTMENTS	7,227,134.62
COVERED CHARGES	141,877,298.38	CONTRACTUAL ALLOW	121,505,139.64
NON-COVERD CHARGES	697,050.00	TOTAL MEDICAID LIAB	20,372,158.74
		LESS: COB	384,445.85
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	19,987,712.89

TOTAL NUMBER OF ADMISSIONS 1,951

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,743	0	15,699,212.00	0.00
ROUTINE NURSERY	2,045	0	8,222,591.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,788	0	23,921,803.00	0.00
SPECIAL CARE SERVICES				
CCU	215	0	1,255,389.00	0.00
ICU	1,987	0	10,680,759.00	0.00
NICU	250	0	2,157,158.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	191	0	1,378,065.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,643	0	15,471,371.00	0.00
TOTAL ACCOMODATIONS	13,431	0	39,393,174.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,924,934.07	22,721.00
MED/SURG SUPPLY	2,133,079.00	14,274.00
LABORATORY-GENERAL	19,298,878.65	1,507.00
RADIOLOGY-DIAGNOSTIC	2,019,784.00	0.00
CT SCAN	7,551,756.00	26,563.00
PHYSICAL THERAPY	1,011,823.00	0.00
EKG/ECG	710,109.00	0.00
IV THERAPY	114,094.00	0.00
OPERATING ROOM	9,785,704.00	38,733.00
LABOR/DELIVERY ROOM	2,038,170.00	0.00
RESPIRATORY SERVICES	5,309,912.00	635.00
ANESTHESIA	1,756,231.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,591,987.00	0.00
RECOVERY ROOM	979,783.00	0.00
LABORATORY PATHOLOGIC	1,001,152.00	0.00
RADIOLOGY THERAPEUTIC	303,600.00	0.00
OCCUPATIONAL THERAPY	687,385.00	0.00
SPEECH PATHOLOGY	539,506.00	0.00
RENAL DIALYSIS	921,191.00	175,825.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,806.00
PSYCHIATRIC SERVICES	3,927.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	802,478.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,878,065.00	32,214.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	418,978.00	58,547.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,466,984.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	431,570.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	136,993.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	568,571.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,649.00	12,430.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,066,421.00	41,523.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	444.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	10,380.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,631,853.66	460.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	242,519.00
IMPL DEV CHARGE PATIENTS	4,387,658.00	16,913.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	9,454.00	0.00

TOTAL ANCILLARY	102,484,124.38	697,050.00
TOTAL ACCOMODATIONS	39,393,174.00	0.00
TOTAL CHARGES	141,877,298.38	697,050.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	5223010070386	12/08/22 - 12/28/22	01/16/23	9,454.00	0.00	0.00	0.00	0.00
TOTAL				9,454.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,135,389.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,128,729.50	CONTRACTUAL ALLOW	976,699.72
NON-COVERD CHARGES	6,660.00	TOTAL MEDICAID LIAB	152,029.78
		LESS: COB	152,029.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	72	0	123,798.00	0.00
ROUTINE NURSERY	35	0	105,490.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	107	0	229,288.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	29	0	150,974.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	29	0	150,974.00	0.00
TOTAL ACCOMODATIONS	136	0	380,262.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,638.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,676.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	135,837.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,274.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,308.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	896.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,212.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	128,061.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	112,669.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,374.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,883.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,793.00	0.00	SPECIAL SERVICES	0.00	6,660.00
RECOVERY ROOM	25,079.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,936.00	0.00	INJECTABLE DRUGS	46,552.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	868.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,123.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,081.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	17,137.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,644.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	36,747.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,679.00	0.00			

TOTAL ANCILLARY	748,467.50	6,660.00
TOTAL ACCOMODATIONS	380,262.00	0.00
TOTAL CHARGES	1,128,729.50	6,660.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,789,921.14	ADJUSTMENTS	1,368,190.37
COVERED CHARGES	25,536,357.55	CONTRACTUAL ALLOW	21,004,041.16
NON-COVERD CHARGES	3,253,563.59	TOTAL MEDICAID LIAB	4,532,316.39
		LESS: COB	8,562.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,523,754.12
		ALL OTHER	3,491,546.34
		FEE SCHEDULE-LAB	301,307.88
		INJECTABLE DRUGS	730,899.90

TOTAL NUMBER OF CLAIMS 5,111

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363,420.05	80,254.22
MED/SURG SUPPLY	203,667.00	7,026.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	745,439.00	9,954.00
CT SCAN	4,144,018.00	631,630.00
PHYSICAL THERAPY	333,807.00	27,235.00
EKG/ECG	335,991.50	1,404.00
IV THERAPY	2,248,407.00	18,555.00
OPERATING ROOM	1,348,946.00	372,485.00
LABOR/DELIVERY ROOM	9,741.00	0.00
RESPIRATORY SERVICES	120,340.25	12,636.00
ANESTHESIA	385,656.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,058,962.00	22,828.00
RECOVERY ROOM	351,755.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	561,294.00	26,654.00
OCCUPATIONAL THERAPY	41,703.00	22,810.00
SPEECH PATHOLOGY	4,549.00	17,291.00
RENAL DIALYSIS	0.00	36,197.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	286,334.00	3,919.00
PSYCHIATRIC SERVICES	28,050.00	27,517.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	996,682.00	107,612.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	83,583.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	241,021.00	73,713.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	488,103.00	82,038.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	51,381.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	377,702.37	13,786.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	218,436.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,590.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,410,272.62	147,608.00
MRI SERVICES	815,106.00	48,451.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	3,996.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,167,490.76	1,285,594.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	168,532.00
IMPL DEV CHARGE PATIENTS	112,910.00	3,838.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	25,536,357.55	3,253,563.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,536,357.55	3,253,563.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	814,164.07	ADJUSTMENTS	0.00
COVERED CHARGES	451,829.30	CONTRACTUAL ALLOW	378,291.21
NON-COVERD CHARGES	362,334.77	TOTAL MEDICAID LIAB	73,538.09
		LESS: COB	73,538.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,591.85	0.00
MED/SURG SUPPLY	4,253.00	3,946.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,963.00	0.00
CT SCAN	26,288.00	48,286.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,956.00	468.00
IV THERAPY	36,360.00	0.00
OPERATING ROOM	11,349.00	48,503.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	635.00	3,744.00
ANESTHESIA	20,050.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	146,230.00	718.00
RECOVERY ROOM	13,636.00	1,623.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,419.00	258.00
PSYCHIATRIC SERVICES	0.00	2,244.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	27,197.00	15,222.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	11,387.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,181.00	3,351.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,369.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,182.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	86,859.00	4,399.00
MRI SERVICES	0.00	10,746.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,310.45	205,491.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,948.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	451,829.30	362,334.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	451,829.30	362,334.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	967,763.58	ADJUSTMENTS	2,081.03
COVERED CHARGES	893,034.31	CONTRACTUAL ALLOW	877,661.54
NON-COVERD CHARGES	74,729.27	TOTAL MEDICAID LIAB	15,372.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,372.77

TOTAL NUMBER OF CLAIMS 229

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,371.43	0.00
MED/SURG SUPPLY	0.00	1,986.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,931.00	0.00
CT SCAN	80,896.00	37,615.00
PHYSICAL THERAPY	0.00	878.00
EKG/ECG	12,168.00	0.00
IV THERAPY	63,054.00	249.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,932.00	2,676.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	460,739.00	1,254.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,958.00	0.00
OCCUPATIONAL THERAPY	0.00	649.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	2,805.00	1,683.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	23,223.00	10,850.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,659.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,595.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	171,639.00	7,030.00
MRI SERVICES	9,454.00	5,373.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,609.88	292.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	4,194.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	893,034.31	74,729.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	893,034.31	74,729.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,717.62	ADJUSTMENTS	0.00
COVERED CHARGES	43,966.62	CONTRACTUAL ALLOW	43,362.45
NON-COVERD CHARGES	751.00	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	698.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,282.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,146.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,668.00	235.00
EKG/ECG	468.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,599.00	516.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,977.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	567.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	561.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	43,966.62	751.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,966.62	751.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,897,335.08	ADJUSTMENTS	276,224.46
COVERED CHARGES	7,383,908.80	CONTRACTUAL ALLOW	6,344,517.95
NON-COVERD CHARGES	513,426.28	TOTAL MEDICAID LIAB	1,039,390.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,039,390.85

TOTAL NUMBER OF CLAIMS 192

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,083.10	2,622.00
MED/SURG SUPPLY	542,560.00	10,911.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,623.00	3,810.00
CT SCAN	199,685.00	45,999.00
PHYSICAL THERAPY	0.00	6,611.00
EKG/ECG	28,126.00	5,148.00
IV THERAPY	356,835.00	5,606.40
OPERATING ROOM	1,649,481.00	111,040.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,527.00	0.00
ANESTHESIA	337,206.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	141,566.00	3,670.00
RECOVERY ROOM	323,976.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	273,678.00	0.00
OCCUPATIONAL THERAPY	0.00	618.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,123.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,984.00	333.00
PSYCHIATRIC SERVICES	0.00	561.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,179.00	7,332.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,330.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,407.00	2,531.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	264,691.00	89,356.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	572.00	1,144.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	42,084.20	380.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,057.00	4,585.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	286,224.95	29,616.00
MRI SERVICES	16,119.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,271,359.55	117,765.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	49,920.00
IMPL DEV CHARGE PATIENTS	1,438,555.00	11,744.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,383,908.80	513,426.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,383,908.80	513,426.28

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	401,708.00	ADJUSTMENTS	0.00
COVERED CHARGES	87,397.00	CONTRACTUAL ALLOW	81,330.47
NON-COVERD CHARGES	314,311.00	TOTAL MEDICAID LIAB	6,066.53
		LESS: COB	6,066.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC.
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,963.00	141.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,551.00	4,220.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,541.00	309,950.00
RADIOLOGY THERAPEUTIC	1,342.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	87,397.00	314,311.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,397.00	314,311.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,022.50	ADJUSTMENTS	5,270.81
COVERED CHARGES	465,686.50	CONTRACTUAL ALLOW	317,774.84
NON-COVERD CHARGES	6,336.00	TOTAL MEDICAID LIAB	147,911.66
		LESS: COB	1,928.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	145,983.27

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	21	0	26,134.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	26,134.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	35	0	72,520.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	35	0	72,520.00	0.00
TOTAL ACCOMODATIONS	56	0	98,654.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,360.50	0.00
MED/SURG SUPPLY	19,911.00	0.00
LABORATORY-GENERAL	108,782.00	0.00
RADIOLOGY-DIAGNOSTIC	5,021.00	0.00
CT SCAN	54,701.00	0.00
PHYSICAL THERAPY	762.00	0.00
EKG/ECG	5,420.00	0.00
IV THERAPY	16,781.00	4,788.00
OPERATING ROOM	3,428.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,926.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,532.00	0.00
RECOVERY ROOM	1,029.00	0.00
LABORATORY PATHOLOGIC	680.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,324.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,931.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,210.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,183.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,144.00	0.00
PROFESSIONAL FEES	0.00	350.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,223.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,541.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,143.00	1,198.00

TOTAL ANCILLARY	367,032.50	6,336.00
TOTAL ACCOMODATIONS	98,654.00	0.00
TOTAL CHARGES	465,686.50	6,336.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2323171000227	04/17/23 - 04/19/23	06/26/23	0.00	1,198.00	0.00	1,928.39	0.00
614	2023209000001	07/12/23 - 07/19/23	07/31/23	4,143.00	0.00	0.00	0.00	0.00
TOTAL				4,143.00	1,198.00	0.00	1,928.39	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,477,876.29	ADJUSTMENTS	81,013.25
COVERED CHARGES	3,173,933.53	CONTRACTUAL ALLOW	2,581,918.89
NON-COVERD CHARGES	303,942.76	TOTAL MEDICAID LIAB	592,014.64
		LESS: COB	952.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	591,062.36
		ALL OTHER	522,116.58
		FEE SCHEDULE-LAB	66,287.30
		INJECTABLE DRUGS	2,658.48

TOTAL NUMBER OF CLAIMS 1,011

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,150.79	269.00
MED/SURG SUPPLY	263,091.50	2,481.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	99,892.00	5,844.00
CT SCAN	558,541.00	110,209.00
PHYSICAL THERAPY	48,211.00	9,142.00
EKG/ECG	37,127.00	3,794.00
IV THERAPY	231,136.00	6,876.00
OPERATING ROOM	312,838.99	62,757.01
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,586.00	560.00
ANESTHESIA	9,597.00	8,280.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	392,975.00	1,526.00
RECOVERY ROOM	106,543.00	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	234.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	38,872.00	1,357.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,589.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,475.00	9,140.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,210.00	5,526.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,276.00	668.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,100.00	529.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	788,918.00	31,893.00
MRI SERVICES	54,626.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74,944.25	38,516.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	4,235.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	340.00

TOTAL ANCILLARY	3,173,933.53	303,942.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,173,933.53	303,942.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8830	5923241000132	08/08/23 - 08/08/23	09/04/23	0.00	340.00	0.00	0.00	0.00
TOTAL				0.00	340.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,140.75	ADJUSTMENTS	0.00
COVERED CHARGES	28,977.00	CONTRACTUAL ALLOW	23,270.38
NON-COVERD CHARGES	13,163.75	TOTAL MEDICAID LIAB	5,706.62
		LESS: COB	5,706.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	475.00	0.00
MED/SURG SUPPLY	4,078.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	528.00
CT SCAN	0.00	4,974.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	271.00
IV THERAPY	2,126.00	2,508.00
OPERATING ROOM	3,428.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,680.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,759.00	191.00
RECOVERY ROOM	1,509.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,906.00	285.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,016.00	3,559.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	847.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	28,977.00	13,163.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,977.00	13,163.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	136,803.25	ADJUSTMENTS	0.00
COVERED CHARGES	128,061.25	CONTRACTUAL ALLOW	125,261.25
NON-COVERD CHARGES	8,742.00	TOTAL MEDICAID LIAB	2,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,800.00

TOTAL NUMBER OF CLAIMS 40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,461.25	0.00
MED/SURG SUPPLY	3,156.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,510.00	0.00
CT SCAN	47,872.00	6,962.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,355.00	0.00
IV THERAPY	7,392.00	391.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,898.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	185.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	920.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,215.00	900.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,097.00	489.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	128,061.25	8,742.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	128,061.25	8,742.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,384.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,798.00	CONTRACTUAL ALLOW	8,728.00
NON-COVERD CHARGES	2,586.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	43.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	4,974.00	2,487.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	271.00	0.00
IV THERAPY	544.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,420.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,226.00	99.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	320.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,798.00	2,586.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,798.00	2,586.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	111,356.60	ADJUSTMENTS	0.00
COVERED CHARGES	103,682.60	CONTRACTUAL ALLOW	87,113.57
NON-COVERD CHARGES	7,674.00	TOTAL MEDICAID LIAB	16,569.03
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	16,569.03

TOTAL NUMBER OF CLAIMS 3

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,185.10	0.00
MED/SURG SUPPLY	9,827.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	662.00	0.00
CT SCAN	15,912.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	542.00	0.00
IV THERAPY	31,465.00	487.00
OPERATING ROOM	10,858.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,006.00	129.00
ANESTHESIA	1,371.00	1,150.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,576.00	0.00
RECOVERY ROOM	2,538.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,228.00	1,133.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,156.00	167.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,858.00	1,084.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,498.00	3,524.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	103,682.60	7,674.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,682.60	7,674.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,201,922.20	ADJUSTMENTS	598,295.89
COVERED CHARGES	32,009,302.91	CONTRACTUAL ALLOW	26,084,399.75
NON-COVERD CHARGES	192,619.29	TOTAL MEDICAID LIAB	5,924,903.16
		LESS: COB	106,536.16
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,818,367.00

TOTAL NUMBER OF ADMISSIONS 624

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,275	0	4,267,304.00	0.00
ROUTINE NURSERY	414	0	827,092.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,689	0	5,094,396.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	979	0	3,315,269.24	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	979	0	3,315,269.24	0.00
TOTAL ACCOMODATIONS	4,668	0	8,409,665.24	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,826,395.74	23,168.19
MED/SURG SUPPLY	657,974.76	1,269.00
LABORATORY-GENERAL	3,559,495.90	0.00
RADIOLOGY-DIAGNOSTIC	915,306.50	0.00
CT SCAN	1,738,453.00	45,404.00
PHYSICAL THERAPY	372,503.00	0.00
EKG/ECG	130,140.00	0.00
IV THERAPY	555,637.00	0.00
OPERATING ROOM	3,358,428.72	4,220.70
LABOR/DELIVERY ROOM	334,214.10	0.00
RESPIRATORY SERVICES	2,342,521.00	0.00
ANESTHESIA	540,969.82	0.00
GI SERVICES	79,477.38	0.00
EMERGENCY ROOM	1,047,459.26	0.00
RECOVERY ROOM	374,260.44	0.00
LABORATORY PATHOLOGIC	140,592.00	0.00
RADIOLOGY THERAPEUTIC	237,505.59	0.00
OCCUPATIONAL THERAPY	120,075.00	0.00
SPEECH PATHOLOGY	154,513.57	0.00
RENAL DIALYSIS	122,844.80	11,348.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	49.00	1,837.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	59,140.40	0.00
OTHER IMAGING SERVICE	196,755.63	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	636,853.90	40,999.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	143,107.41	55,143.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	313,857.05	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,615.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	118,502.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	161,752.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	9,229.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	332,318.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,845,150.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	151,769.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	23,599,637.67	192,619.29
TOTAL ACCOMODATIONS	8,409,665.24	0.00
TOTAL CHARGES	32,009,302.91	192,619.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	222,653.20	ADJUSTMENTS	0.00
COVERED CHARGES	222,653.20	CONTRACTUAL ALLOW	168,402.98
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	54,250.22
		LESS: COB	54,250.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	11	0	14,333.00	0.00
ROUTINE NURSERY	32	0	66,490.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	43	0	80,823.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	43	0	80,823.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,211.00	0.00
MED/SURG SUPPLY	2,239.00	0.00
LABORATORY-GENERAL	18,259.00	0.00
RADIOLOGY-DIAGNOSTIC	1,430.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	270.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	29,529.00	0.00
LABOR/DELIVERY ROOM	35,811.60	0.00
RESPIRATORY SERVICES	89.00	0.00
ANESTHESIA	18,120.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	10,578.42	0.00
LABORATORY PATHOLOGIC	592.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,040.05	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,035.43	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	461.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,907.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,961.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	7,296.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	141,830.20	0.00
TOTAL ACCOMODATIONS	80,823.00	0.00
TOTAL CHARGES	222,653.20	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,184,738.77	ADJUSTMENTS	510,306.69
COVERED CHARGES	21,575,427.61	CONTRACTUAL ALLOW	17,629,983.46
NON-COVERD CHARGES	2,609,311.16	TOTAL MEDICAID LIAB	3,945,444.15
		LESS: COB	4,069.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,941,375.12
		ALL OTHER	2,818,314.17
		FEE SCHEDULE-LAB	196,436.37
		INJECTABLE DRUGS	926,624.58

TOTAL NUMBER OF CLAIMS 6,135

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,591.83	22,229.91
MED/SURG SUPPLY	310,423.58	10,946.00
LABORATORY-GENERAL	0.00	510.00
RADIOLOGY-DIAGNOSTIC	581,873.75	120,347.25
CT SCAN	2,048,470.00	240,008.00
PHYSICAL THERAPY	26,291.00	4,492.00
EKG/ECG	123,390.00	13,230.00
IV THERAPY	1,984,932.52	152,070.60
OPERATING ROOM	3,851,951.35	350,881.22
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	363,709.30	2,697.20
ANESTHESIA	804,156.78	0.00
GI SERVICES	185,375.31	20,346.45
EMERGENCY ROOM	2,341,193.32	134,423.74
RECOVERY ROOM	675,626.58	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,671,990.79	77,264.14
OCCUPATIONAL THERAPY	8,370.00	2,464.00
SPEECH PATHOLOGY	0.00	2,013.78
RENAL DIALYSIS	0.00	8,228.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	128,503.20	3,899.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	686,109.34	115,874.47
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	346,630.90	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	48,662.57	236,711.56
AUDIOLOGY	66,262.42	6,260.00
CARDIOLOGY	43,077.30	12,297.90
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	275,248.47	18,002.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	162,257.32	2,129.60
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	73.50
OTHER THERAPEUTIC SVC	0.00	544.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,695,169.70	110,578.90
MRI SERVICES	346,454.00	47,891.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,618,722.28	865,844.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	101,984.00	27,050.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,575,427.61	2,609,311.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,575,427.61	2,609,311.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	782,106.93	ADJUSTMENTS	0.00
COVERED CHARGES	310,932.58	CONTRACTUAL ALLOW	266,537.90
NON-COVERD CHARGES	471,174.35	TOTAL MEDICAID LIAB	44,394.68
		LESS: COB	44,394.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,761.00	1,731.00
MED/SURG SUPPLY	12,832.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,917.45	1,667.80
CT SCAN	3,035.00	19,298.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,160.00	0.00
IV THERAPY	28,544.80	342.00
OPERATING ROOM	41,261.23	160,206.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	41,446.68	0.00
GI SERVICES	0.00	2,069.58
EMERGENCY ROOM	38,459.38	0.00
RECOVERY ROOM	39,231.24	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	20,068.26	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,046.85	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,342.88	12,092.02
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,490.39	8,460.00
AUDIOLOGY	8,079.52	184.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,185.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,234.00	1,731.20
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,836.82	250,214.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	13,178.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	310,932.58	471,174.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	310,932.58	471,174.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	264,802.35	ADJUSTMENTS	268.52
COVERED CHARGES	254,086.16	CONTRACTUAL ALLOW	244,285.18
NON-COVERD CHARGES	10,716.19	TOTAL MEDICAID LIAB	9,800.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,800.98

TOTAL NUMBER OF CLAIMS 146

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	483.14	464.35
MED/SURG SUPPLY	23.43	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,098.20	0.00
CT SCAN	26,229.00	7,446.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,080.00	0.00
IV THERAPY	27,105.00	1,095.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	144,491.24	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,914.14	766.43
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,029.30	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,653.54	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,696.60	345.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,282.57	599.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	254,086.16	10,716.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	254,086.16	10,716.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,897.26	ADJUSTMENTS	0.00
COVERED CHARGES	12,181.86	CONTRACTUAL ALLOW	11,644.82
NON-COVERD CHARGES	2,715.40	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	1,216.00
CT SCAN	1,526.00	1,473.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	342.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,324.80	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	875.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,084.00	26.40
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	29.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,181.86	2,715.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,181.86	2,715.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,627,648.66	ADJUSTMENTS	157,791.90
COVERED CHARGES	3,279,775.47	CONTRACTUAL ALLOW	2,617,052.29
NON-COVERD CHARGES	347,873.19	TOTAL MEDICAID LIAB	662,723.18
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	662,723.18

TOTAL NUMBER OF CLAIMS 126

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,242.26	1,248.21
MED/SURG SUPPLY	81,620.78	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,824.75	84,767.00
CT SCAN	0.00	6,962.00
PHYSICAL THERAPY	0.00	1,059.00
EKG/ECG	1,620.00	540.00
IV THERAPY	57,694.00	4,000.00
OPERATING ROOM	384,280.13	37,140.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	100,183.38	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,569.30	0.00
RECOVERY ROOM	53,127.72	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	203,999.90	23,130.20
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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	236,561.60	0.00
OTHER IMAGING SERVICE	6,311.36	906.27
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,992.30	5,124.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,869.01	658.00
AUDIOLOGY	3,758.26	184.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	20,060.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,338.00	2,391.60
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,872,176.12	59,243.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	188,546.00	120,518.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,279,775.47	347,873.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,279,775.47	347,873.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	102,930.71	ADJUSTMENTS	5,525.79
COVERED CHARGES	102,930.71	CONTRACTUAL ALLOW	43,788.46
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	59,142.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	59,142.25

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	29	0	16,675.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	16,675.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	29	0	16,675.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,245.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,951.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,568.89	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,523.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,360.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,715.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,597.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,192.76	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,556.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,410.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	767.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	570.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,714.16	0.00			

TOTAL ANCILLARY	86,255.71	0.00
TOTAL ACCOMODATIONS	16,675.00	0.00
TOTAL CHARGES	102,930.71	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	341,214.61	ADJUSTMENTS	43,897.43
COVERED CHARGES	330,585.75	CONTRACTUAL ALLOW	106,616.81
NON-COVERD CHARGES	10,628.86	TOTAL MEDICAID LIAB	223,968.94
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	223,968.94
		ALL OTHER	204,643.44
		FEE SCHEDULE-LAB	19,288.00
		INJECTABLE DRUGS	37.50

TOTAL NUMBER OF CLAIMS 378

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,395.10	0.00
MED/SURG SUPPLY	12,954.82	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,339.60	1,620.00
CT SCAN	51,501.80	0.00
PHYSICAL THERAPY	10,351.45	72.00
EKG/ECG	8,962.40	0.00
IV THERAPY	26,762.84	347.10
OPERATING ROOM	7,315.00	189.09
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,033.52	1,360.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,532.00	0.00
RECOVERY ROOM	420.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,939.85	320.00
SPEECH PATHOLOGY	123.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	270.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,984.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,919.80	1,006.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,083.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	253.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,120.07	533.27

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	626.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	92,789.15	4,911.20
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	179.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	330,585.75	10,628.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	330,585.75	10,628.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	39,095.20	ADJUSTMENTS	140.00
COVERED CHARGES	38,901.70	CONTRACTUAL ALLOW	35,191.70
NON-COVERD CHARGES	193.50	TOTAL MEDICAID LIAB	3,710.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,710.00

TOTAL NUMBER OF CLAIMS 53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,219.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	196.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,895.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,573.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,888.59	193.50
EKG/ECG	847.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	815.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,466.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	38,901.70	193.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,901.70	193.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,109.56	ADJUSTMENTS	6,058.77
COVERED CHARGES	17,703.56	CONTRACTUAL ALLOW	5,586.02
NON-COVERD CHARGES	406.00	TOTAL MEDICAID LIAB	12,117.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,117.54

TOTAL NUMBER OF CLAIMS 2

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,211.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,180.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	840.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,280.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,813.00	406.00
EKG/ECG	2,076.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,602.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	164.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	720.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816.00	0.00			

TOTAL ANCILLARY	17,703.56	406.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,703.56	406.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,528,436.09	ADJUSTMENTS	529,659.70
COVERED CHARGES	10,408,321.09	CONTRACTUAL ALLOW	7,920,403.74
NON-COVERD CHARGES	120,115.00	TOTAL MEDICAID LIAB	2,487,917.35
		LESS: COB	86,861.50
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	945.00
		REIMBURSEMENT	2,402,000.85

TOTAL NUMBER OF ADMISSIONS 337

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	842	0	905,957.00	0.00
ROUTINE NURSERY	82	0	81,750.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	924	0	987,707.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	193	0	358,485.00	0.00
NICU	4	0	5,588.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	197	0	364,073.00	0.00
TOTAL ACCOMODATIONS	1,121	0	1,351,780.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,168,564.55	495.00
MED/SURG SUPPLY	124,030.00	591.00
LABORATORY-GENERAL	2,280,987.00	0.00
RADIOLOGY-DIAGNOSTIC	238,407.00	0.00
CT SCAN	594,699.00	33,942.00
PHYSICAL THERAPY	101,813.00	0.00
EKG/ECG	163,822.00	0.00
IV THERAPY	133,997.00	0.00
OPERATING ROOM	914,824.00	0.00
LABOR/DELIVERY ROOM	107,222.00	0.00
RESPIRATORY SERVICES	546,888.00	90.00
ANESTHESIA	174,093.00	0.00
GI SERVICES	70,848.00	7,816.00
EMERGENCY ROOM	248,685.00	0.00
RECOVERY ROOM	55,564.00	0.00
LABORATORY PATHOLOGIC	30,321.00	0.00
RADIOLOGY THERAPEUTIC	2,594.00	0.00
OCCUPATIONAL THERAPY	13,328.00	0.00
SPEECH PATHOLOGY	5,501.00	0.00
RENAL DIALYSIS	70,602.00	5,592.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	326.00	871.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	46,466.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,923.00	43,812.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	123,435.00	3,048.00
AUDIOLOGY	16,580.00	0.00
CARDIOLOGY	880,115.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	854.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	307,049.47	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	73,530.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	112,361.00	0.00
PROFESSIONAL FEES	0.00	590.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	23,268.00
INJECTABLE DRUGS	122,819.03	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	308,158.04	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,135.00	0.00

TOTAL ANCILLARY	9,056,541.09	120,115.00
TOTAL ACCOMODATIONS	1,351,780.00	0.00
TOTAL CHARGES	10,408,321.09	120,115.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2024074046333	06/28/23 - 07/06/23	03/18/24	3,135.00	0.00	0.00	0.00	0.00
TOTAL				3,135.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	376,991.19	ADJUSTMENTS	0.00
COVERED CHARGES	371,576.19	CONTRACTUAL ALLOW	311,964.34
NON-COVERD CHARGES	5,415.00	TOTAL MEDICAID LIAB	59,611.85
		LESS: COB	59,674.85
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	26	0	28,996.00	0.00
ROUTINE NURSERY	3	0	3,120.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	32,116.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	1,899.00	0.00
NICU	4	0	5,588.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	7,487.00	0.00
TOTAL ACCOMODATIONS	34	0	39,603.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,369.00	0.00
MED/SURG SUPPLY	33,740.00	0.00
LABORATORY-GENERAL	50,802.00	0.00
RADIOLOGY-DIAGNOSTIC	18,096.00	0.00
CT SCAN	13,790.00	2,981.00
PHYSICAL THERAPY	4,090.00	0.00
EKG/ECG	3,570.00	0.00
IV THERAPY	2,816.00	0.00
OPERATING ROOM	19,919.00	0.00
LABOR/DELIVERY ROOM	33,870.00	0.00
RESPIRATORY SERVICES	9,809.00	0.00
ANESTHESIA	4,728.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,612.00	0.00
RECOVERY ROOM	1,916.00	0.00
LABORATORY PATHOLOGIC	710.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,150.00	0.00
SPEECH PATHOLOGY	346.00	0.00
RENAL DIALYSIS	1,681.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	954.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,277.00	2,434.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,212.00	0.00
CARDIOLOGY	92,843.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,889.18	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,799.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,890.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,365.01	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	730.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	331,973.19	5,415.00
TOTAL ACCOMODATIONS	39,603.00	0.00
TOTAL CHARGES	371,576.19	5,415.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,992,983.93	ADJUSTMENTS	402,861.90
COVERED CHARGES	11,366,943.63	CONTRACTUAL ALLOW	9,453,500.76
NON-COVERD CHARGES	626,040.30	TOTAL MEDICAID LIAB	1,913,442.87
		LESS: COB	501.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,912,941.43
		ALL OTHER	1,688,740.44
		FEE SCHEDULE-LAB	171,814.97
		INJECTABLE DRUGS	52,386.02

TOTAL NUMBER OF CLAIMS 3,216

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343,431.00	7,992.00
MED/SURG SUPPLY	75,517.00	2,638.01
LABORATORY-GENERAL	0.00	4,884.00
RADIOLOGY-DIAGNOSTIC	397,916.98	14,505.00
CT SCAN	1,630,511.00	30,813.00
PHYSICAL THERAPY	138,922.00	3,403.00
EKG/ECG	202,021.99	2,142.00
IV THERAPY	882,655.00	6,014.00
OPERATING ROOM	604,368.00	85,855.00
LABOR/DELIVERY ROOM	6,714.00	0.00
RESPIRATORY SERVICES	143,310.00	9,104.00
ANESTHESIA	192,933.00	0.00
GI SERVICES	139,064.00	300.00
EMERGENCY ROOM	906,006.11	5,570.01
RECOVERY ROOM	53,648.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	20,139.00	0.00
OCCUPATIONAL THERAPY	54,351.00	6,165.00
SPEECH PATHOLOGY	2,768.00	346.00
RENAL DIALYSIS	0.00	84,263.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,429.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	260,077.00	8,560.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,901.00	1,217.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	370,337.00	14,425.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	717,372.00	19,117.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	854.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	703,167.42	34,136.78

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	95,227.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,347,891.90	120,237.00
MRI SERVICES	448,862.00	7,821.00
PROFESSIONAL FEES	0.00	592.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	304.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	70,251.00
INJECTABLE DRUGS	514,500.23	85,689.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	81,234.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	7,511.00	0.00

TOTAL ANCILLARY	11,366,943.63	626,040.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,366,943.63	626,040.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023299066653	06/13/23 - 06/13/23	10/30/23	4,376.00	0.00	0.00	0.00	876.85
615	5923341000446	11/10/23 - 11/10/23	12/11/23	3,135.00	0.00	0.00	0.00	628.18
TOTAL				7,511.00	0.00	0.00	0.00	1,505.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,263.43	ADJUSTMENTS	0.00
COVERED CHARGES	93,306.37	CONTRACTUAL ALLOW	78,130.59
NON-COVERD CHARGES	57,957.06	TOTAL MEDICAID LIAB	15,175.78
		LESS: COB	15,175.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,791.00	1,503.00
MED/SURG SUPPLY	3,003.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,407.00	852.00
CT SCAN	5,909.00	1,883.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,380.00	0.00
IV THERAPY	8,545.00	229.00
OPERATING ROOM	9,577.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	489.00	0.00
ANESTHESIA	3,093.00	0.00
GI SERVICES	0.00	7,816.00
EMERGENCY ROOM	12,436.00	0.00
RECOVERY ROOM	958.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	692.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,233.00	684.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	29,431.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,004.37	2,714.06

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	953.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,157.00	1,093.00
MRI SERVICES	0.00	8,964.00
PROFESSIONAL FEES	0.00	118.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	975.00	400.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	396.00	1,578.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	93,306.37	57,957.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,306.37	57,957.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	475,897.85	ADJUSTMENTS	626.56
COVERED CHARGES	466,268.81	CONTRACTUAL ALLOW	449,351.56
NON-COVERD CHARGES	9,629.04	TOTAL MEDICAID LIAB	16,917.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	16,917.25

TOTAL NUMBER OF CLAIMS 229

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,918.99	51.00
MED/SURG SUPPLY	139.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,200.98	0.00
CT SCAN	129,489.00	1,883.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,140.00	0.00
IV THERAPY	29,784.00	0.00
OPERATING ROOM	13,360.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,024.00	0.00
ANESTHESIA	3,093.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	122,539.13	916.00
RECOVERY ROOM	958.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,957.00	624.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,419.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	106,826.91	4,394.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,419.00	1,761.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	466,268.81	9,629.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	466,268.81	9,629.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,530.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,371.00	CONTRACTUAL ALLOW	10,057.71
NON-COVERD CHARGES	159.00	TOTAL MEDICAID LIAB	313.29
		LESS: COB	313.29
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	0.00
CT SCAN	1,883.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	915.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,206.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,295.99	159.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,371.00	159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,371.00	159.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,404,892.63	ADJUSTMENTS	174,706.27
COVERED CHARGES	3,272,529.80	CONTRACTUAL ALLOW	2,963,198.00
NON-COVERD CHARGES	132,362.83	TOTAL MEDICAID LIAB	309,331.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	309,331.80

TOTAL NUMBER OF CLAIMS 57

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,442.00	0.00
MED/SURG SUPPLY	139,157.00	1,384.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,847.00	43,464.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,316.00	295.00
EKG/ECG	4,522.00	0.00
IV THERAPY	12,065.00	162.00
OPERATING ROOM	819,896.25	42,349.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,097.00	0.00
ANESTHESIA	86,781.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,806.00	0.00
RECOVERY ROOM	24,908.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	17,568.00	0.00
OCCUPATIONAL THERAPY	416.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,770.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,812.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	263,465.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	393,311.51	19,011.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,640.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,728.00	1,121.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	803,268.04	24,576.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	596,714.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,272,529.80	132,362.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,272,529.80	132,362.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,761,922.65	ADJUSTMENTS	1,430,878.09
COVERED CHARGES	59,668,396.11	CONTRACTUAL ALLOW	52,415,752.26
NON-COVERD CHARGES	93,526.54	TOTAL MEDICAID LIAB	7,252,643.85
		LESS: COB	113,732.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,197.00
		REIMBURSEMENT	7,140,108.29

TOTAL NUMBER OF ADMISSIONS 761

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,233	0	7,354,529.25	0.00
ROUTINE NURSERY	88	0	308,338.90	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	37.00
TOTAL ROUTINE	3,321	0	7,662,868.15	37.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	757	0	3,630,871.00	0.00
NICU	3	0	18,474.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	760	0	3,649,345.00	0.00
TOTAL ACCOMODATIONS	4,081	0	11,312,213.15	37.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,830,347.02	0.00
MED/SURG SUPPLY	838,540.62	2,158.00
LABORATORY-GENERAL	15,276,449.65	0.00
RADIOLOGY-DIAGNOSTIC	1,667,018.38	0.00
CT SCAN	6,256,404.18	8,929.20
PHYSICAL THERAPY	729,083.20	0.00
EKG/ECG	508,097.80	0.00
IV THERAPY	579,965.07	0.00
OPERATING ROOM	3,507,295.98	0.00
LABOR/DELIVERY ROOM	82,021.46	5,146.90
RESPIRATORY SERVICES	1,847,193.83	0.00
ANESTHESIA	866,321.90	0.00
GI SERVICES	257,322.94	0.00
EMERGENCY ROOM	1,598,136.11	0.00
RECOVERY ROOM	416,686.00	0.00
LABORATORY PATHOLOGIC	146,145.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	483,631.05	0.00
SPEECH PATHOLOGY	109,675.85	0.00
RENAL DIALYSIS	224,509.20	11,627.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,935.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,651.20	0.00
OTHER IMAGING SERVICE	732,713.45	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	285,072.85	59,691.49
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	33,607.36	5,936.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,933,945.74	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	63,362.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	399,827.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	353,992.28	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,356,335.62	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	955,893.35	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	48,356,182.96	93,489.54
TOTAL ACCOMODATIONS	11,312,213.15	37.00
TOTAL CHARGES	59,668,396.11	93,526.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2023163006964	05/19/23 - 06/08/23	06/19/23	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	335,920.55	ADJUSTMENTS	0.00
COVERED CHARGES	335,920.55	CONTRACTUAL ALLOW	288,341.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	47,579.21
		LESS: COB	47,642.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	19	0	28,229.25	0.00
ROUTINE NURSERY	2	0	7,113.65	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	35,342.90	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	5,445.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	5,445.00	0.00
TOTAL ACCOMODATIONS	22	0	40,787.90	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,665.43	0.00	OTHER LAB	2,753.10	0.00
MED/SURG SUPPLY	5,201.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	49,234.63	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,111.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	589.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	625.53	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,589.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	71,862.38	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,549.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,450.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,317.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,280.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,670.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,526.30	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,763.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,722.00	0.00			

TOTAL ANCILLARY	295,132.65	0.00
TOTAL ACCOMODATIONS	40,787.90	0.00
TOTAL CHARGES	335,920.55	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,885,366.70	ADJUSTMENTS	114,608.80
COVERED CHARGES	20,367,462.49	CONTRACTUAL ALLOW	19,169,764.22
NON-COVERD CHARGES	3,517,904.21	TOTAL MEDICAID LIAB	1,197,698.27
		LESS: COB	4,605.49
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,193,092.78
		ALL OTHER	1,005,519.23
		FEE SCHEDULE-LAB	178,192.66
		INJECTABLE DRUGS	9,380.89

TOTAL NUMBER OF CLAIMS 2,532

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304,149.38	1,497.60
MED/SURG SUPPLY	188,612.51	241,120.19
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,248,240.20	12,268.20
CT SCAN	4,696,789.65	737,180.89
PHYSICAL THERAPY	0.00	34,282.44
EKG/ECG	528,175.20	13,548.15
IV THERAPY	799,365.72	88,164.30
OPERATING ROOM	884,162.38	282,953.62
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	105,176.00	40,168.45
ANESTHESIA	227,593.80	0.00
GI SERVICES	50,131.62	12,448.00
EMERGENCY ROOM	3,844,426.55	2,482.00
RECOVERY ROOM	309,674.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	20,399.40
SPEECH PATHOLOGY	0.00	12,354.30
RENAL DIALYSIS	0.00	41,435.10
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	178.50	2,917.75
PSYCHIATRIC SERVICES	8,089.20	7,078.05
LITHOTRIPSY	10,651.20	0.00
OTHER IMAGING SERVICE	342,084.45	65,027.55
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,166.30	4,254.68
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	50,247.75	3,895.95
AUDIOLOGY	0.00	0.00
CARDIOLOGY	542,866.80	1,206,363.69
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,563.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	375,540.97	1,860.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	304,569.18	3,322.63
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,069,293.32	209,065.70
MRI SERVICES	158,222.40	119,124.60
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,002.33
INJECTABLE DRUGS	122,413.42	157,623.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	162,078.99	193,065.02
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,367,462.49	3,517,904.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,367,462.49	3,517,904.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	319,227.41	ADJUSTMENTS	0.00
COVERED CHARGES	166,537.32	CONTRACTUAL ALLOW	156,081.94
NON-COVERD CHARGES	152,690.09	TOTAL MEDICAID LIAB	10,455.38
		LESS: COB	10,455.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,238.49	83.20
MED/SURG SUPPLY	9,557.69	39,756.47
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,135.60	0.00
CT SCAN	17,236.80	24,886.05
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,890.50	0.00
IV THERAPY	5,004.30	1,112.77
OPERATING ROOM	0.00	17,302.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,054.20	0.00
ANESTHESIA	2,400.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	31,159.80	0.00
RECOVERY ROOM	11,562.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,651.20	0.00
OTHER IMAGING SERVICE	3,123.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,141.35	84.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	63,915.60
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,094.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,904.95	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	38,546.76	737.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	835.93	3,951.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	861.22
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	166,537.32	152,690.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	166,537.32	152,690.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,022,686.98	ADJUSTMENTS	268.52
COVERED CHARGES	2,894,777.68	CONTRACTUAL ALLOW	2,854,029.76
NON-COVERD CHARGES	127,909.30	TOTAL MEDICAID LIAB	40,747.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	40,747.92

TOTAL NUMBER OF CLAIMS 608

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,016.44	83.20
MED/SURG SUPPLY	5,290.85	952.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	243,360.60	2,410.80
CT SCAN	936,722.85	51,104.55
PHYSICAL THERAPY	0.00	1,110.44
EKG/ECG	66,562.65	589.05
IV THERAPY	121,155.71	17,104.85
OPERATING ROOM	552.00	13,578.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	182.00	0.00
ANESTHESIA	2,400.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	874,792.31	0.00
RECOVERY ROOM	6,531.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,073.10
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	42,255.15	6,266.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,976.64	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,998.11	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	29,433.62	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	471,502.96	13,622.03
MRI SERVICES	55,142.85	9,140.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,338.52	10,874.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	563.42	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,894,777.68	127,909.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,894,777.68	127,909.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,824.46	ADJUSTMENTS	0.00
COVERED CHARGES	22,161.37	CONTRACTUAL ALLOW	21,624.33
NON-COVERD CHARGES	7,663.09	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83.20	0.00
MED/SURG SUPPLY	251.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,055.90	0.00
CT SCAN	0.00	7,425.60
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	589.05	0.00
IV THERAPY	1,232.33	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,115.30	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,803.39	170.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31.20	67.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,161.37	7,663.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,161.37	7,663.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	878,000.49	ADJUSTMENTS	16,023.56
COVERED CHARGES	742,840.55	CONTRACTUAL ALLOW	721,503.17
NON-COVERD CHARGES	135,159.94	TOTAL MEDICAID LIAB	21,337.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,337.38

TOTAL NUMBER OF CLAIMS 4

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,994.51	0.00
MED/SURG SUPPLY	328,312.75	1,410.24
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,286.10	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	589.05	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,859.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	113.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	14,031.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,296.60	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	322,878.15	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,011.23	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,608.74	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,084.02	441.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	43,775.50	133,308.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	742,840.55	135,159.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	742,840.55	135,159.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTER, LLC
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,575,215.68	ADJUSTMENTS	920,082.82
COVERED CHARGES	35,433,852.68	CONTRACTUAL ALLOW	29,836,275.90
NON-COVERD CHARGES	141,363.00	TOTAL MEDICAID LIAB	5,597,576.78
		LESS: COB	56,088.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,331.00
		REIMBURSEMENT	5,543,819.57

TOTAL NUMBER OF ADMISSIONS 588

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,067	0	3,776,303.00	0.00
ROUTINE NURSERY	216	0	383,901.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	12.00
TOTAL ROUTINE	2,283	0	4,160,204.00	12.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	570	0	3,011,146.00	0.00
NICU	8	0	50,168.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	578	0	3,061,314.00	0.00
TOTAL ACCOMODATIONS	2,861	0	7,221,518.00	12.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,991,291.46	0.00
MED/SURG SUPPLY	577,285.49	2,163.00
LABORATORY-GENERAL	6,296,340.00	0.00
RADIOLOGY-DIAGNOSTIC	401,932.00	0.00
CT SCAN	2,572,358.43	7,399.00
PHYSICAL THERAPY	193,590.00	0.00
EKG/ECG	323,505.00	0.00
IV THERAPY	742,504.00	0.00
OPERATING ROOM	1,970,627.00	0.00
LABOR/DELIVERY ROOM	364,856.00	279.00
RESPIRATORY SERVICES	3,452,273.00	0.00
ANESTHESIA	219,490.00	0.00
GI SERVICES	245,372.00	0.00
EMERGENCY ROOM	1,845,421.00	0.00
RECOVERY ROOM	416,103.00	0.00
LABORATORY PATHOLOGIC	128,552.00	0.00
RADIOLOGY THERAPEUTIC	74,017.00	0.00
OCCUPATIONAL THERAPY	61,817.00	0.00
SPEECH PATHOLOGY	71,116.00	0.00
RENAL DIALYSIS	636,087.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	18,952.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	207,413.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	180,351.00	118,536.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	78,836.03	12,974.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,614,804.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	63,094.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	302,796.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	260,575.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	344,649.03	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	551,870.74	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,456.00	0.00

TOTAL ANCILLARY	28,212,334.68	141,351.00
TOTAL ACCOMODATIONS	7,221,518.00	12.00
TOTAL CHARGES	35,433,852.68	141,363.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023252022163	12/03/22 - 12/08/22	09/18/23	4,456.00	0.00	0.00	0.00	0.00
TOTAL				4,456.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,229.92	ADJUSTMENTS	0.00
COVERED CHARGES	180,535.92	CONTRACTUAL ALLOW	152,425.95
NON-COVERD CHARGES	2,694.00	TOTAL MEDICAID LIAB	28,109.97
		LESS: COB	28,172.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	19	0	34,656.00	0.00
ROUTINE NURSERY	2	0	2,478.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	37,134.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	21	0	37,134.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,242.81	0.00
MED/SURG SUPPLY	3,493.27	0.00
LABORATORY-GENERAL	18,783.00	0.00
RADIOLOGY-DIAGNOSTIC	598.00	0.00
CT SCAN	2,893.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.00	0.00
IV THERAPY	5,462.00	0.00
OPERATING ROOM	10,926.00	0.00
LABOR/DELIVERY ROOM	28,270.00	0.00
RESPIRATORY SERVICES	279.00	0.00
ANESTHESIA	2,718.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,220.00	0.00
RECOVERY ROOM	16,515.00	0.00
LABORATORY PATHOLOGIC	657.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,263.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,772.00	2,694.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	16,443.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,313.84	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	143,401.92	2,694.00
TOTAL ACCOMODATIONS	37,134.00	0.00
TOTAL CHARGES	180,535.92	2,694.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,913,800.18	ADJUSTMENTS	995,637.21
COVERED CHARGES	22,145,697.50	CONTRACTUAL ALLOW	19,274,415.79
NON-COVERD CHARGES	2,768,102.68	TOTAL MEDICAID LIAB	2,871,281.71
		LESS: COB	7,993.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,863,288.24
		ALL OTHER	1,780,843.43
		FEE SCHEDULE-LAB	118,173.30
		INJECTABLE DRUGS	964,271.51

TOTAL NUMBER OF CLAIMS 3,570

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	335,640.32	956.80
MED/SURG SUPPLY	422,731.51	59,926.13
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	503,121.00	5,400.00
CT SCAN	2,782,364.00	492,566.05
PHYSICAL THERAPY	51,677.00	21,230.00
EKG/ECG	251,062.00	9,954.00
IV THERAPY	1,171,614.00	130,671.00
OPERATING ROOM	2,057,483.36	323,518.64
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	123,199.00	29,721.00
ANESTHESIA	295,981.00	0.00
GI SERVICES	218,709.00	69,781.00
EMERGENCY ROOM	3,768,854.02	2,664.00
RECOVERY ROOM	466,381.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	664,571.00	34,808.00
OCCUPATIONAL THERAPY	2,263.00	4,415.00
SPEECH PATHOLOGY	2,232.00	2,806.00
RENAL DIALYSIS	0.00	11,212.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	603.00	4,478.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	667,119.00	75,376.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	37,502.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	58,799.00	213,919.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	364,902.00	125,564.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	284,204.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	588,654.04	21,542.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	222,264.00	4,869.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,456,473.00	99,358.00
MRI SERVICES	137,904.00	112,042.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,169,682.29	175,228.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	39,707.96	736,096.07
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,145,697.50	2,768,102.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,145,697.50	2,768,102.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	938,603.61	ADJUSTMENTS	0.00
COVERED CHARGES	274,759.86	CONTRACTUAL ALLOW	247,174.72
NON-COVERD CHARGES	663,843.75	TOTAL MEDICAID LIAB	27,585.14
		LESS: COB	27,585.14
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,049.29	499.20
MED/SURG SUPPLY	3,122.61	0.00
LABORATORY-GENERAL	0.00	882.00
RADIOLOGY-DIAGNOSTIC	8,660.00	0.00
CT SCAN	15,471.00	31,336.00
PHYSICAL THERAPY	0.00	678.00
EKG/ECG	4,977.00	0.00
IV THERAPY	21,576.00	3,657.00
OPERATING ROOM	36,482.00	3,977.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	93.00	0.00
ANESTHESIA	8,036.00	0.00
GI SERVICES	0.00	3,941.00
EMERGENCY ROOM	83,927.00	0.00
RECOVERY ROOM	8,699.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,770.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,628.00	16,398.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,701.00	3,680.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,159.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,833.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,452.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,835.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	41,320.00	2,916.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,968.96	595,879.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	274,759.86	663,843.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	274,759.86	663,843.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,563,896.74	ADJUSTMENTS	402.78
COVERED CHARGES	1,506,089.21	CONTRACTUAL ALLOW	1,480,244.16
NON-COVERD CHARGES	57,807.53	TOTAL MEDICAID LIAB	25,845.05
		LESS: COB	66.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,778.65

TOTAL NUMBER OF CLAIMS 385

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,895.10	0.00
MED/SURG SUPPLY	399.81	249.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,165.00	0.00
CT SCAN	349,432.00	30,303.01
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	25,438.00	0.00
IV THERAPY	138,354.00	15,621.00
OPERATING ROOM	11,130.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,386.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	683,795.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,135.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,532.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,670.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	202,509.00	4,568.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,247.80	7,065.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,506,089.21	57,807.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,506,089.21	57,807.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	71,077.37	ADJUSTMENTS	0.00
COVERED CHARGES	64,119.11	CONTRACTUAL ALLOW	63,313.55
NON-COVERD CHARGES	6,958.26	TOTAL MEDICAID LIAB	805.56
		LESS: COB	805.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203.11	83.20
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,612.00	0.00
CT SCAN	0.00	5,786.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,871.00	0.00
IV THERAPY	5,987.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,278.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,116.00	920.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52.00	169.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	64,119.11	6,958.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,119.11	6,958.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,959,125.26	ADJUSTMENTS	150,603.66
COVERED CHARGES	5,469,222.51	CONTRACTUAL ALLOW	5,131,869.69
NON-COVERD CHARGES	489,902.75	TOTAL MEDICAID LIAB	337,352.82
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	337,352.82

TOTAL NUMBER OF CLAIMS 56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,825.83	83.20
MED/SURG SUPPLY	99,339.84	10,705.64
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,745.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	9,331.00
EKG/ECG	553.00	0.00
IV THERAPY	20,534.00	557.00
OPERATING ROOM	402,877.33	22,208.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,865.00	2,750.00
ANESTHESIA	74,871.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,110.00	0.00
RECOVERY ROOM	109,248.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	23,043.00	0.00
OCCUPATIONAL THERAPY	0.00	535.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,246.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,080.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	118,172.00	25,507.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,531.55	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,986.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,560.00	1,464.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,369,864.21	37,776.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	181,770.75	378,984.86
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,469,222.51	489,902.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,469,222.51	489,902.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/22	THROUGH	08/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	136,089,064.02	ADJUSTMENTS	7,902,226.54
COVERED CHARGES	134,159,093.06	CONTRACTUAL ALLOW	107,300,661.23
NON-COVERD CHARGES	1,929,970.96	TOTAL MEDICAID LIAB	26,858,431.83
		LESS: COB	460,405.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	756.00
		REIMBURSEMENT	26,398,782.05

TOTAL NUMBER OF ADMISSIONS 2,013

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,128	0	20,142,881.00	0.00
ROUTINE NURSERY	1,389	0	4,762,225.22	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12,517	0	24,905,106.22	0.00
SPECIAL CARE SERVICES				
CCU	17	0	138,397.00	0.00
ICU	3,415	0	20,662,207.00	0.00
NICU	159	0	1,157,520.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,591	0	21,958,124.00	0.00
TOTAL ACCOMODATIONS	16,108	0	46,863,230.22	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,697,265.07	0.00
MED/SURG SUPPLY	3,518,889.65	2,717.76
LABORATORY-GENERAL	19,200,653.32	0.00
RADIOLOGY-DIAGNOSTIC	1,296,452.00	0.00
CT SCAN	3,592,758.00	22,312.00
PHYSICAL THERAPY	1,121,645.50	0.00
EKG/ECG	839,380.00	0.00
IV THERAPY	562,430.00	0.00
OPERATING ROOM	10,761,888.00	22,278.00
LABOR/DELIVERY ROOM	678,085.00	1,452.00
RESPIRATORY SERVICES	8,894,845.00	0.00
ANESTHESIA	2,523,827.00	0.00
GI SERVICES	724,411.00	7,104.00
EMERGENCY ROOM	4,334,768.00	0.00
RECOVERY ROOM	642,981.00	0.00
LABORATORY PATHOLOGIC	392,691.00	575.00
RADIOLOGY THERAPEUTIC	322,184.00	0.00
OCCUPATIONAL THERAPY	673,010.00	0.00
SPEECH PATHOLOGY	192,885.00	202.00
RENAL DIALYSIS	1,403,234.00	76,714.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	19,988.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	832,432.50	576,784.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,206,349.26	627,532.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	47,953.00	176,014.02
AUDIOLOGY	60,219.00	0.00
CARDIOLOGY	6,057,500.50	0.00
AMBULATORY SURGERY	1,395.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	220,077.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,459,302.00	182,329.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	907,740.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	224.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,152,049.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	223,159.18
INJECTABLE DRUGS	3,924,952.28	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	8,634.00
IMPL DEV CHARGE PATIENTS	1,716,245.26	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	315,153.00	2,164.00

TOTAL ANCILLARY	87,295,862.84	1,929,970.96
TOTAL ACCOMODATIONS	46,863,230.22	0.00
TOTAL CHARGES	134,159,093.06	1,929,970.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022308126173	10/10/22 - 10/24/22	11/14/22	3,812.00	0.00	0.00	0.00	0.00
614	2022334082593	11/09/22 - 11/16/22	12/05/22	7,624.00	0.00	0.00	0.00	0.00
614	2222339005080	10/18/22 - 10/26/22	12/12/22	4,592.00	0.00	0.00	0.00	0.00
614	2222342010378	10/25/22 - 10/27/22	12/12/22	3,812.00	0.00	0.00	0.00	0.00
614	2222350007842	10/10/22 - 10/22/22	12/19/22	3,812.00	0.00	0.00	0.00	0.00
615	2022364000223	12/19/22 - 12/24/22	01/02/23	7,624.00	0.00	0.00	0.00	0.00
614	5923002000211	10/08/22 - 10/12/22	01/09/23	3,812.00	0.00	0.00	0.00	0.00
614	2023013000070	12/10/22 - 12/21/22	01/16/23	3,812.00	0.00	0.00	0.00	0.00
614	5923023001166	11/18/22 - 11/22/22	01/30/23	2,296.00	0.00	0.00	0.00	0.00
614	2023024055243	12/20/22 - 12/30/22	01/30/23	7,624.00	0.00	0.00	0.00	0.00
614	2223033001938	12/27/22 - 01/01/23	02/06/23	3,812.00	0.00	0.00	0.00	0.00
614	2223037002463	12/31/22 - 01/06/23	02/13/23	2,296.00	0.00	0.00	0.00	0.00
615	2223038001245	10/07/22 - 10/09/22	02/13/23	6,108.00	0.00	0.00	0.00	0.00
614	2223039008418	11/06/22 - 11/12/22	02/13/23	3,358.00	0.00	0.00	0.00	0.00
614	5223044000275	12/09/22 - 01/07/23	02/20/23	3,812.00	0.00	0.00	0.00	0.00
615	2223046005766	01/10/23 - 01/12/23	02/20/23	6,108.00	0.00	0.00	0.00	0.00
614	2223047007400	12/09/22 - 12/27/22	02/20/23	2,115.00	0.00	0.00	0.00	0.00
614	2223051000434	01/11/23 - 01/17/23	02/27/23	3,812.00	0.00	0.00	0.00	0.00
615	2023051037811	02/10/23 - 02/16/23	02/27/23	6,108.00	0.00	0.00	0.00	0.00
615	5223052000367	10/23/22 - 11/08/22	02/27/23	6,108.00	0.00	0.00	0.00	0.00
614	2023052069577	02/13/23 - 02/18/23	02/27/23	2,296.00	0.00	0.00	0.00	0.00
614	2223062008836	01/11/23 - 01/20/23	03/06/23	2,296.00	0.00	0.00	0.00	0.00
615	2223062008836	01/11/23 - 01/20/23	03/06/23	3,812.00	0.00	0.00	0.00	0.00
614	5923065000899	12/14/22 - 01/07/23	03/13/23	3,358.00	0.00	0.00	0.00	0.00
614	5223066060436	01/28/23 - 02/16/23	03/13/23	2,296.00	0.00	0.00	0.00	0.00
615	2223068007782	10/13/22 - 10/19/22	03/13/23	6,108.00	0.00	0.00	0.00	0.00
614	2223068010912	02/01/23 - 02/07/23	03/13/23	3,358.00	0.00	0.00	0.00	0.00
614	2223075000800	11/19/22 - 11/22/22	03/20/23	12,216.00	0.00	0.00	0.00	0.00
615	2023075078018	03/07/23 - 03/11/23	03/20/23	11,436.00	0.00	0.00	0.00	0.00
615	2223080002284	10/26/22 - 11/18/22	03/27/23	7,624.00	0.00	0.00	0.00	0.00
614	2223087007966	09/27/22 - 10/04/22	04/03/23	4,592.00	0.00	0.00	0.00	0.00
614	2023094054674	03/18/23 - 03/23/23	04/10/23	3,812.00	0.00	0.00	0.00	0.00
615	5223095000588	01/07/23 - 01/19/23	04/10/23	7,624.00	0.00	0.00	0.00	0.00
614	2223101008358	12/13/22 - 12/22/22	04/17/23	2,376.00	0.00	0.00	0.00	0.00
615	2023102085137	04/01/23 - 04/07/23	04/17/23	7,624.00	0.00	0.00	0.00	0.00
614	5923107001036	02/19/23 - 03/04/23	04/24/23	2,296.00	0.00	0.00	0.00	0.00
614	5923107001004	02/23/23 - 03/03/23	04/24/23	7,624.00	0.00	0.00	0.00	0.00
614	2023114044023	04/13/23 - 04/20/23	05/01/23	3,812.00	0.00	0.00	0.00	0.00
614	5223117070217	12/01/22 - 12/30/22	05/01/23	3,812.00	0.00	0.00	0.00	0.00
614	2223121000920	02/26/23 - 03/03/23	05/08/23	3,812.00	0.00	0.00	0.00	0.00
614	2223121002945	03/13/23 - 04/11/23	05/08/23	2,296.00	0.00	0.00	0.00	0.00
615	5223123000320	04/13/23 - 04/21/23	05/08/23	2,296.00	0.00	0.00	0.00	0.00

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2023125000137	04/26/23 - 05/01/23	05/08/23	3,812.00	0.00	0.00	0.00	0.00
614	2223158009471	01/16/23 - 02/06/23	06/19/23	3,812.00	0.00	0.00	0.00	0.00
615	2023160115849	04/26/23 - 05/16/23	06/19/23	11,436.00	0.00	0.00	0.00	0.00
615	2223163000993	02/11/23 - 02/17/23	06/19/23	7,624.00	0.00	0.00	0.00	0.00
615	2023177026327	05/16/23 - 05/21/23	07/03/23	7,624.00	0.00	0.00	0.00	0.00
618	2023180000144	05/26/23 - 06/08/23	07/03/23	0.00	2,164.00	0.00	0.00	0.00
614	5223192000299	11/07/22 - 12/19/22	07/17/23	3,812.00	0.00	0.00	0.00	0.00
615	2223200008784	06/12/23 - 06/15/23	07/31/23	11,436.00	0.00	0.00	0.00	0.00
615	2023201106553	06/26/23 - 06/28/23	07/24/23	2,296.00	0.00	0.00	0.00	0.00
614	2223206006194	04/20/23 - 04/30/23	07/31/23	3,812.00	0.00	0.00	0.00	0.00
615	2223212004318	07/07/23 - 07/13/23	08/07/23	7,624.00	0.00	0.00	0.00	0.00
615	5223222000282	05/16/23 - 06/02/23	08/14/23	11,436.00	0.00	0.00	0.00	0.00
615	2023233042874	06/26/23 - 07/06/23	08/28/23	7,624.00	0.00	0.00	0.00	0.00
615	2023241065445	08/20/23 - 08/25/23	09/04/23	7,624.00	0.00	0.00	0.00	0.00
615	2223250012080	05/27/23 - 06/02/23	09/11/23	2,296.00	0.00	0.00	0.00	0.00
615	5223267093731	06/28/23 - 07/25/23	10/02/23	2,296.00	0.00	0.00	0.00	0.00
615	2323285000272	02/28/23 - 03/06/23	10/16/23	7,624.00	0.00	0.00	3,827.46	0.00
615	2323310000029	08/10/23 - 08/17/23	11/13/23	7,624.00	0.00	0.00	1,115.97	0.00
615	2323334000345	01/10/23 - 01/23/23	12/04/23	2,296.00	0.00	0.00	5,718.38	0.00
615	2024005107563	04/13/23 - 04/27/23	01/15/24	3,812.00	0.00	0.00	0.00	0.00
TOTAL				315,153.00	2,164.00	0.00	10,661.81	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,730,151.88	ADJUSTMENTS	0.00
COVERED CHARGES	2,675,325.97	CONTRACTUAL ALLOW	2,241,235.19
NON-COVERD CHARGES	54,825.91	TOTAL MEDICAID LIAB	434,090.78
		LESS: COB	434,090.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	175	0	316,225.00	0.00
ROUTINE NURSERY	32	0	85,288.48	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	207	0	401,513.48	0.00
SPECIAL CARE SERVICES				
CCU	1	0	8,141.00	0.00
ICU	67	0	423,347.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	68	0	431,488.00	0.00
TOTAL ACCOMODATIONS	275	0	833,001.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,036.49	0.00
MED/SURG SUPPLY	43,212.05	0.00
LABORATORY-GENERAL	371,443.00	0.00
RADIOLOGY-DIAGNOSTIC	37,885.00	0.00
CT SCAN	46,953.00	3,128.00
PHYSICAL THERAPY	5,783.00	0.00
EKG/ECG	13,464.00	0.00
IV THERAPY	11,464.00	0.00
OPERATING ROOM	153,813.00	0.00
LABOR/DELIVERY ROOM	273,979.00	0.00
RESPIRATORY SERVICES	158,452.00	0.00
ANESTHESIA	115,510.00	0.00
GI SERVICES	5,350.00	0.00
EMERGENCY ROOM	59,664.00	0.00
RECOVERY ROOM	11,053.00	0.00
LABORATORY PATHOLOGIC	8,329.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,119.00	0.00
SPEECH PATHOLOGY	1,993.00	0.00
RENAL DIALYSIS	25,394.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	869.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,589.00	18,114.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	39,326.00	19,425.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	7,872.00
AUDIOLOGY	2,637.00	0.00
CARDIOLOGY	70,281.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,423.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	65,045.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,460.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	17,544.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	6,286.91
INJECTABLE DRUGS	35,301.37	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	44,952.58	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,842,324.49	54,825.91
TOTAL ACCOMODATIONS	833,001.48	0.00
TOTAL CHARGES	2,675,325.97	54,825.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,137,295.04	ADJUSTMENTS	1,111,426.84
COVERED CHARGES	37,429,685.96	CONTRACTUAL ALLOW	27,992,023.81
NON-COVERD CHARGES	8,707,609.08	TOTAL MEDICAID LIAB	9,437,662.15
		LESS: COB	42,712.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,394,949.20
		ALL OTHER	5,188,742.09
		FEE SCHEDULE-LAB	611,552.66
		INJECTABLE DRUGS	3,594,654.45

TOTAL NUMBER OF CLAIMS 12,484

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	549,216.85	152,313.62
MED/SURG SUPPLY	353,485.71	5,017.00
LABORATORY-GENERAL	0.00	4,186.00
RADIOLOGY-DIAGNOSTIC	701,428.00	168,632.00
CT SCAN	2,222,983.00	839,788.00
PHYSICAL THERAPY	616.00	8,469.00
EKG/ECG	743,175.00	9,180.00
IV THERAPY	2,066,441.00	57,578.00
OPERATING ROOM	1,911,635.03	962,147.97
LABOR/DELIVERY ROOM	16,344.00	2,326.00
RESPIRATORY SERVICES	196,767.00	60,680.00
ANESTHESIA	674,832.00	0.00
GI SERVICES	135,168.00	175,984.00
EMERGENCY ROOM	6,291,800.00	28,072.00
RECOVERY ROOM	464,162.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,734,849.00	230,797.00
OCCUPATIONAL THERAPY	0.00	6,465.00
SPEECH PATHOLOGY	1,194.00	14,624.00
RENAL DIALYSIS	0.00	133,296.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,336.00	8,565.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	710,155.00	839,840.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	897,842.23	75,670.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	360,553.00	569,561.55
AUDIOLOGY	1,194.00	5,373.00
CARDIOLOGY	846,420.00	600,562.00
AMBULATORY SURGERY	0.00	465.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,629.00	2,344.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,114,872.89	305,271.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	380,161.00	244.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	848.00
OTHER THERAPEUTIC SVC	0.00	4,848.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,126,174.97	1,148,999.57
MRI SERVICES	634,119.00	155,519.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	527.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	749.95	5,749.62
INJECTABLE DRUGS	4,004,616.84	1,709,309.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	9,432.49	328,605.36
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	263,806.00	86,279.00

TOTAL ANCILLARY	37,429,685.96	8,707,609.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,429,685.96	8,707,609.08

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022292128306	10/11/22 - 10/11/22	10/24/22	3,812.00	0.00	0.00	0.00	781.33
780	2022299084068	10/12/22 - 10/12/22	10/31/22	38.00	0.00	0.00	0.00	20.52
614	2022301093568	10/21/22 - 10/21/22	11/07/22	3,812.00	0.00	0.00	0.00	781.33
780	2022311060530	10/05/22 - 10/05/22	11/14/22	38.00	0.00	0.00	0.00	20.52
780	2022312065989	10/27/22 - 10/27/22	11/14/22	38.00	0.00	0.00	0.00	20.52
780	2022312066053	11/02/22 - 11/02/22	11/14/22	38.00	0.00	0.00	0.00	20.52
780	2022313093693	10/05/22 - 10/05/22	11/14/22	38.00	0.00	0.00	0.00	20.52
614	2022329058301	10/24/22 - 10/24/22	12/05/22	3,812.00	0.00	0.00	0.00	781.33
614	2022329058301	10/24/22 - 10/24/22	12/05/22	3,812.00	0.00	0.00	0.00	781.33
614	2022336088879	11/16/22 - 11/16/22	12/12/22	3,812.00	0.00	0.00	0.00	781.33
614	2022339046971	12/02/22 - 12/02/22	12/12/22	3,812.00	0.00	0.00	0.00	781.33
780	2022339047580	12/01/22 - 12/01/22	12/12/22	38.00	0.00	0.00	0.00	20.52
614	2022342106252	12/05/22 - 12/05/22	12/12/22	3,812.00	0.00	0.00	0.00	781.33
614	2022344013411	12/06/22 - 12/06/22	12/19/22	3,812.00	0.00	0.00	0.00	781.33
614	2022356083614	12/16/22 - 12/16/22	12/26/22	3,812.00	0.00	0.00	0.00	781.33
614	5923002000288	10/20/22 - 10/20/22	01/09/23	3,812.00	0.00	0.00	0.00	781.33
614	2023006105675	01/03/23 - 01/03/23	01/16/23	0.00	2,376.00	0.00	0.00	0.00
614	2023006105723	01/03/23 - 01/03/23	01/16/23	3,812.00	0.00	0.00	0.00	781.33
780	2023010058745	01/06/23 - 01/06/23	01/16/23	38.00	0.00	0.00	0.00	20.52
780	2023010058746	12/09/22 - 12/09/22	01/16/23	38.00	0.00	0.00	0.00	20.52
614	2023013032573	12/30/22 - 12/30/22	01/16/23	3,812.00	0.00	0.00	0.00	781.33
614	2023013090073	10/26/22 - 10/26/22	01/23/23	3,812.00	0.00	0.00	0.00	781.33
614	2023013090073	10/26/22 - 10/26/22	01/23/23	3,812.00	0.00	0.00	0.00	781.33
614	2023013089524	01/10/23 - 01/10/23	01/23/23	3,812.00	0.00	0.00	0.00	781.33
614	2023019022607	10/27/22 - 10/27/22	01/23/23	2,296.00	0.00	0.00	0.00	470.60
614	2023019022607	10/27/22 - 10/27/22	01/23/23	0.00	1,831.00	0.00	0.00	0.00
614	2023019108731	11/02/22 - 11/02/22	01/23/23	0.00	3,812.00	0.00	0.00	0.00
614	2023019108731	11/02/22 - 11/02/22	01/23/23	0.00	3,812.00	0.00	0.00	0.00
614	2023023043721	01/20/23 - 01/20/23	01/30/23	3,812.00	0.00	0.00	0.00	781.33
615	2023025076115	12/25/22 - 12/25/22	01/30/23	0.00	3,812.00	0.00	0.00	0.00
615	2023025076115	12/25/22 - 12/25/22	01/30/23	3,812.00	0.00	0.00	0.00	781.33
614	2023026080266	01/23/23 - 01/23/23	01/30/23	3,812.00	0.00	0.00	0.00	781.33
614	2023030039269	01/27/23 - 01/27/23	02/06/23	3,812.00	0.00	0.00	0.00	781.33
614	2023037054108	02/02/23 - 02/02/23	02/13/23	3,812.00	0.00	0.00	0.00	781.33
614	2023037054108	02/02/23 - 02/02/23	02/13/23	3,812.00	0.00	0.00	0.00	781.33
614	2023045065241	01/30/23 - 01/30/23	02/20/23	3,812.00	0.00	0.00	0.00	781.33
614	2023045062843	11/17/22 - 11/17/22	02/20/23	3,812.00	0.00	0.00	0.00	781.33
614	2023045062843	11/17/22 - 11/17/22	02/20/23	3,812.00	0.00	0.00	0.00	781.33
614	2023047087077	11/03/22 - 11/03/22	02/20/23	0.00	3,812.00	0.00	0.00	0.00
614	2023047087078	02/13/23 - 02/13/23	02/20/23	3,812.00	0.00	0.00	0.00	781.33
614	2223051003901	12/15/22 - 12/15/22	02/27/23	3,812.00	0.00	0.00	0.00	781.33
614	2223051003901	12/15/22 - 12/15/22	02/27/23	3,812.00	0.00	0.00	0.00	781.33

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780	2023051038013	02/17/23 - 02/17/23	02/27/23	38.00	0.00	0.00	0.00	20.52
614	2023051038258	02/17/23 - 02/17/23	02/27/23	3,812.00	0.00	0.00	0.00	781.33
614	2023051038258	02/17/23 - 02/17/23	02/27/23	3,812.00	0.00	0.00	0.00	781.33
614	5923052000281	12/12/22 - 12/12/22	02/27/23	0.00	3,358.00	0.00	0.00	0.00
614	5923052000281	12/12/22 - 12/12/22	02/27/23	0.00	2,296.00	0.00	0.00	0.00
614	2023052070795	01/21/23 - 01/21/23	02/27/23	0.00	3,812.00	0.00	0.00	0.00
614	2223054011044	10/26/22 - 10/26/22	02/27/23	3,812.00	0.00	0.00	0.00	781.33
614	2023054114700	02/20/23 - 02/20/23	02/27/23	3,812.00	0.00	0.00	0.00	781.33
614	2023054114700	02/20/23 - 02/20/23	02/27/23	3,812.00	0.00	0.00	0.00	781.33
780	2023054114873	02/20/23 - 02/20/23	02/27/23	38.00	0.00	0.00	0.00	20.52
780	2023055099106	11/18/22 - 11/18/22	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023055099134	02/21/23 - 02/21/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023055099160	01/19/23 - 01/19/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023055099194	01/24/23 - 01/24/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023059017799	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043215	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043229	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043232	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043234	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043532	02/20/23 - 02/20/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043658	02/22/23 - 02/22/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043754	02/23/23 - 02/23/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058043940	02/23/23 - 02/23/23	03/06/23	38.00	0.00	0.00	0.00	20.52
614	2023058043973	02/23/23 - 02/23/23	03/06/23	3,812.00	0.00	0.00	0.00	781.33
780	2023058044018	02/24/23 - 02/24/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023061116103	02/27/23 - 02/27/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023062086883	02/28/23 - 02/28/23	03/13/23	38.00	0.00	0.00	0.00	20.52
614	2023062087260	02/23/23 - 02/23/23	03/13/23	3,812.00	0.00	0.00	0.00	781.33
614	2023062087260	02/23/23 - 02/23/23	03/13/23	3,812.00	0.00	0.00	0.00	781.33
780	2023065039362	03/03/23 - 03/03/23	03/13/23	38.00	0.00	0.00	0.00	20.52
780	2023066079906	03/03/23 - 03/03/23	03/13/23	38.00	0.00	0.00	0.00	20.52
780	2023068126405	03/06/23 - 03/06/23	03/13/23	38.00	0.00	0.00	0.00	20.52
615	2023068126406	02/06/23 - 02/06/23	03/13/23	3,812.00	0.00	0.00	0.00	781.33
780	2023068126454	03/03/23 - 03/03/23	03/13/23	38.00	0.00	0.00	0.00	20.52
780	2023069097502	03/07/23 - 03/07/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023069097696	03/07/23 - 03/07/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023069097845	03/07/23 - 03/07/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023070017077	03/03/23 - 03/03/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023072045381	03/08/23 - 03/08/23	03/20/23	38.00	0.00	0.00	0.00	20.52
614	2023072046329	03/08/23 - 03/08/23	03/20/23	3,812.00	0.00	0.00	0.00	781.33
780	2023072046447	03/10/23 - 03/10/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023072046449	03/10/23 - 03/10/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023073071749	03/10/23 - 03/10/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023073071836	03/10/23 - 03/10/23	03/20/23	38.00	0.00	0.00	0.00	20.52
614	2023073071868	02/09/23 - 02/09/23	03/20/23	0.00	2,115.00	0.00	0.00	0.00
614	2023073071868	02/09/23 - 02/09/23	03/20/23	0.00	1,831.00	0.00	0.00	0.00

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780	2023074081474	02/03/23 - 02/03/23	03/20/23	38.00	0.00	0.00	6.09	14.43
780	2023075081184	11/10/22 - 11/10/22	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023075078065	01/09/23 - 01/09/23	03/20/23	38.00	0.00	0.00	0.00	20.52
615	5923076000111	10/14/22 - 10/14/22	03/20/23	0.00	2,296.00	0.00	0.00	0.00
615	5923076000111	10/14/22 - 10/14/22	03/20/23	2,296.00	0.00	0.00	0.00	470.60
614	2023080023361	03/15/23 - 03/15/23	03/27/23	3,812.00	0.00	0.00	0.00	781.33
614	2023080023361	03/15/23 - 03/15/23	03/27/23	3,812.00	0.00	0.00	0.00	781.33
780	2023081011814	03/16/23 - 03/16/23	03/27/23	38.00	0.00	0.00	0.00	20.52
780	5923082001811	01/19/23 - 01/19/23	03/27/23	38.00	0.00	0.00	0.00	20.52
780	2023082108647	03/20/23 - 03/20/23	03/27/23	38.00	0.00	0.00	0.00	20.52
614	2023083090591	03/21/23 - 03/21/23	04/03/23	3,812.00	0.00	0.00	0.00	781.33
614	2023083090591	03/21/23 - 03/21/23	04/03/23	0.00	3,812.00	0.00	0.00	0.00
780	2023083090634	03/21/23 - 03/21/23	04/03/23	38.00	0.00	0.00	0.00	20.52
615	2023083090650	02/21/23 - 02/21/23	04/03/23	0.00	2,296.00	0.00	0.00	0.00
780	2023087004744	03/22/23 - 03/22/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023087005439	03/22/23 - 03/22/23	04/03/23	38.00	0.00	0.00	0.00	20.52
614	2023087005491	01/26/23 - 01/26/23	04/03/23	5,380.00	0.00	0.00	0.00	1,102.71
614	2023087005494	03/22/23 - 03/22/23	04/03/23	3,812.00	0.00	0.00	0.00	781.33
780	2023087005615	03/22/23 - 03/22/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023087005972	03/22/23 - 03/22/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023086059010	03/22/23 - 03/22/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023086059279	03/24/23 - 03/24/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023086059284	03/21/23 - 03/21/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023089097439	03/27/23 - 03/27/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023089097441	03/27/23 - 03/27/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023091023014	03/23/23 - 03/23/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023091025689	03/28/23 - 03/28/23	04/10/23	38.00	0.00	0.00	0.00	20.52
615	2023093050673	03/01/23 - 03/01/23	04/10/23	0.00	3,812.00	0.00	0.00	0.00
615	2023093050673	03/01/23 - 03/01/23	04/10/23	3,812.00	0.00	0.00	0.00	781.33
780	2023093044553	03/29/23 - 03/29/23	04/10/23	38.00	0.00	0.00	0.00	20.52
614	2023093047027	03/30/23 - 03/30/23	04/10/23	3,812.00	0.00	0.00	0.00	781.33
780	5923094001173	01/03/23 - 01/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001174	11/29/22 - 11/29/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001175	10/28/22 - 10/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001176	11/15/22 - 11/15/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001177	11/11/22 - 11/11/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001178	11/07/22 - 11/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001179	02/09/23 - 02/09/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001180	12/28/22 - 12/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001181	10/18/22 - 10/18/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001182	12/21/22 - 12/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001183	01/03/23 - 01/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001184	01/20/23 - 01/20/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001185	12/07/22 - 12/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001186	01/04/23 - 01/04/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001187	01/30/23 - 01/30/23	04/10/23	38.00	0.00	0.00	0.00	20.52

EMORY UNIVERSITY HOSPITAL MIDTOWN
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	5923094001189	01/18/23 - 01/18/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001190	12/13/22 - 12/13/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001191	10/17/22 - 10/17/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001192	12/02/22 - 12/02/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001193	02/03/23 - 02/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001194	10/28/22 - 10/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001195	10/14/22 - 10/14/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001196	10/12/22 - 10/12/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001197	10/17/22 - 10/17/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001198	01/05/23 - 01/05/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001199	12/06/22 - 12/06/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001200	11/29/22 - 11/29/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001201	12/22/22 - 12/22/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001202	12/09/22 - 12/09/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001203	02/08/23 - 02/08/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001204	11/09/22 - 11/09/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001205	01/12/23 - 01/12/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001206	12/21/22 - 12/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001207	10/21/22 - 10/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001208	10/11/22 - 10/11/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001209	01/23/23 - 01/23/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001210	01/24/23 - 01/24/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001211	11/08/22 - 11/08/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001212	12/21/22 - 12/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001213	11/28/22 - 11/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001214	01/04/23 - 01/04/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001215	11/02/22 - 11/02/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001216	12/15/22 - 12/15/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001217	12/21/22 - 12/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001218	01/13/23 - 01/13/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001219	01/23/23 - 01/23/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001220	12/06/22 - 12/06/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001221	01/03/23 - 01/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001222	01/26/23 - 01/26/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001223	11/30/22 - 11/30/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001224	12/28/22 - 12/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001225	12/07/22 - 12/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001226	12/09/22 - 12/09/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001227	11/09/22 - 11/09/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001228	01/05/23 - 01/05/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001229	01/31/23 - 01/31/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001230	10/31/22 - 10/31/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001231	11/15/22 - 11/15/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001232	01/10/23 - 01/10/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001233	11/23/22 - 11/23/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001234	12/07/22 - 12/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52

EMORY UNIVERSITY HOSPITAL MIDTOWN
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	5923094001235	01/03/23 - 01/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001236	10/28/22 - 10/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001237	11/04/22 - 11/04/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001238	01/12/23 - 01/12/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001240	01/03/23 - 01/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001241	12/28/22 - 12/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001242	11/30/22 - 11/30/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001111	10/26/22 - 10/26/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001112	12/21/22 - 12/21/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001113	10/10/22 - 10/10/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023094054384	03/29/23 - 03/29/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001114	02/08/23 - 02/08/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001115	02/01/23 - 02/01/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001116	02/02/23 - 02/02/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001117	12/13/22 - 12/13/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001118	12/14/22 - 12/14/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001119	01/05/23 - 01/05/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001120	11/03/22 - 11/03/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001121	02/06/23 - 02/06/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001122	01/13/23 - 01/13/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001123	10/14/22 - 10/14/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001124	11/11/22 - 11/11/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001125	11/09/22 - 11/09/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001126	01/04/23 - 01/04/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001127	11/18/22 - 11/18/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001128	12/13/22 - 12/13/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001129	02/01/23 - 02/01/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001130	01/10/23 - 01/10/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001131	01/10/23 - 01/10/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001132	12/22/22 - 12/22/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001136	02/01/23 - 02/01/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001137	01/06/23 - 01/06/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001138	12/08/22 - 12/08/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001139	11/22/22 - 11/22/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001140	11/07/22 - 11/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001141	01/05/23 - 01/05/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001142	12/07/22 - 12/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001143	11/29/22 - 11/29/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001144	12/27/22 - 12/27/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001145	01/25/23 - 01/25/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001146	01/27/23 - 01/27/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001147	11/02/22 - 11/02/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001149	10/28/22 - 10/28/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001150	01/27/23 - 01/27/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001151	12/14/22 - 12/14/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001152	12/05/22 - 12/05/22	04/10/23	38.00	0.00	0.00	0.00	20.52

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SERVICE DATES 09/01/22 THROUGH 08/31/23
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780	5923094001153	12/16/22 - 12/16/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001154	02/01/23 - 02/01/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001155	11/30/22 - 11/30/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001156	01/11/23 - 01/11/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001157	12/07/22 - 12/07/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001158	02/08/23 - 02/08/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001159	11/18/22 - 11/18/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001160	12/29/22 - 12/29/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923094001161	01/24/23 - 01/24/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923095001306	01/20/23 - 01/20/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923095001307	11/18/22 - 11/18/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923095001308	12/22/22 - 12/22/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923095001309	11/18/22 - 11/18/22	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923097000039	01/24/23 - 01/24/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023097026572	04/03/23 - 04/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023097028016	03/20/23 - 03/20/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023097029427	04/03/23 - 04/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	5923097001037	10/24/22 - 10/24/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001038	11/07/22 - 11/07/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001046	02/02/23 - 02/02/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023097090601	04/04/23 - 04/04/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023097090602	04/04/23 - 04/04/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001089	11/10/22 - 11/10/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001091	01/25/23 - 01/25/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001092	12/29/22 - 12/29/22	04/17/23	38.00	0.00	0.00	0.00	20.52
614	2023097090721	03/02/23 - 03/02/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
614	2023097090721	03/02/23 - 03/02/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
780	5923097001093	01/09/23 - 01/09/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001094	12/30/22 - 12/30/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001095	11/02/22 - 11/02/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923097001096	11/21/22 - 11/21/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	5923100001028	10/24/22 - 10/24/22	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023100041850	04/07/23 - 04/07/23	04/17/23	38.00	0.00	0.00	0.00	20.52
614	2023101082119	03/08/23 - 03/08/23	04/17/23	0.00	2,296.00	0.00	0.00	0.00
780	2023101082332	04/06/23 - 04/06/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023104060390	01/24/23 - 01/24/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023104062157	03/28/23 - 03/28/23	04/17/23	38.00	0.00	0.00	0.00	20.52
614	2023104062316	03/24/23 - 03/24/23	04/17/23	3,812.00	0.00	0.00	0.00	781.33
614	2023104062316	03/24/23 - 03/24/23	04/17/23	3,812.00	0.00	0.00	0.00	781.33
780	2023104085693	03/27/23 - 03/27/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023104085739	04/11/23 - 04/11/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023107055855	04/12/23 - 04/12/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023107056174	12/09/22 - 12/09/22	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023107057006	04/12/23 - 04/12/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923107001030	02/15/23 - 02/15/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923107001035	02/14/23 - 02/14/23	04/24/23	38.00	0.00	0.00	0.00	20.52

EMORY UNIVERSITY HOSPITAL MIDTOWN
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	5923107001037	02/15/23 - 02/15/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923107001038	02/17/23 - 02/17/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923107001044	02/17/23 - 02/17/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923109001285	01/23/23 - 01/23/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	5923109001286	03/01/23 - 03/01/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023114043197	04/19/23 - 04/19/23	05/01/23	38.00	0.00	0.00	0.00	20.52
780	2023114043203	04/19/23 - 04/19/23	05/01/23	38.00	0.00	0.00	0.00	20.52
780	2023114043208	04/19/23 - 04/19/23	05/01/23	38.00	0.00	0.00	0.00	20.52
614	2023114043537	04/20/23 - 04/20/23	05/01/23	3,812.00	0.00	0.00	0.00	781.33
614	2023114043537	04/20/23 - 04/20/23	05/01/23	3,812.00	0.00	0.00	0.00	781.33
780	2023114043598	04/21/23 - 04/21/23	05/01/23	38.00	0.00	0.00	0.00	20.52
780	2023116024384	04/19/23 - 04/19/23	05/01/23	38.00	0.00	0.00	0.00	20.52
614	2023116024431	04/22/23 - 04/22/23	05/01/23	3,812.00	0.00	0.00	0.00	781.33
780	2023117093957	04/24/23 - 04/24/23	05/01/23	38.00	0.00	0.00	0.00	20.52
780	2223118008648	12/02/22 - 12/02/22	05/01/23	38.00	0.00	0.00	0.00	20.52
614	2023118090214	04/25/23 - 04/25/23	05/08/23	3,812.00	0.00	0.00	0.00	781.33
780	2023121058281	04/27/23 - 04/27/23	05/08/23	38.00	0.00	0.00	0.00	20.52
614	2023121058511	04/28/23 - 04/28/23	05/08/23	3,812.00	0.00	0.00	0.00	781.33
780	2023121058522	02/28/23 - 02/28/23	05/08/23	38.00	0.00	0.00	0.00	20.52
780	2023123118964	04/20/23 - 04/20/23	05/08/23	38.00	0.00	0.00	0.00	20.52
780	2023125031352	05/01/23 - 05/01/23	05/08/23	38.00	0.00	0.00	0.00	20.52
614	2023125098371	05/02/23 - 05/02/23	05/15/23	3,812.00	0.00	0.00	0.00	781.33
614	2023125098371	05/02/23 - 05/02/23	05/15/23	3,812.00	0.00	0.00	0.00	781.33
780	2023125098513	04/27/23 - 04/27/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023128038548	05/03/23 - 05/03/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023128038717	05/03/23 - 05/03/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023129071004	03/27/23 - 03/27/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023129071100	04/21/23 - 04/21/23	05/15/23	38.00	0.00	0.00	0.00	20.52
614	5923130000453	03/17/23 - 03/17/23	05/15/23	2,376.00	0.00	0.00	0.00	486.99
780	2023131098661	05/08/23 - 05/08/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023131098683	05/08/23 - 05/08/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023131098685	05/08/23 - 05/08/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023133024476	05/09/23 - 05/09/23	05/22/23	38.00	0.00	0.00	0.00	20.52
780	2023135042358	05/10/23 - 05/10/23	05/22/23	38.00	0.00	0.00	0.00	20.52
780	2023135042622	05/11/23 - 05/11/23	05/22/23	38.00	0.00	0.00	0.00	20.52
615	2023140026514	05/16/23 - 05/16/23	05/29/23	0.00	2,296.00	0.00	0.00	0.00
780	2023143066706	01/23/23 - 01/23/23	05/29/23	38.00	0.00	0.00	0.00	20.52
780	2023153097276	02/20/23 - 02/20/23	06/12/23	38.00	0.00	0.00	0.00	20.52
614	5923167000169	12/30/22 - 12/30/22	06/19/23	2,296.00	0.00	0.00	0.00	470.60
615	2023170044417	05/30/23 - 05/30/23	06/26/23	3,812.00	0.00	0.00	0.00	781.33
780	2023180018981	04/19/23 - 04/19/23	07/03/23	38.00	0.00	0.00	0.00	20.52
615	2023180019757	06/21/23 - 06/21/23	07/03/23	3,812.00	0.00	0.00	0.00	781.33
615	2023208112785	07/05/23 - 07/05/23	07/31/23	0.00	3,812.00	0.00	0.00	0.00
615	2023208112785	07/05/23 - 07/05/23	07/31/23	3,812.00	0.00	0.00	0.00	781.33
614	2023229086621	08/13/23 - 08/13/23	08/21/23	3,812.00	0.00	0.00	0.00	781.33
615	2023229086621	08/13/23 - 08/13/23	08/21/23	0.00	3,812.00	0.00	0.00	0.00

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2023236131195	07/31/23 - 07/31/23	08/28/23	3,812.00	0.00	0.00	0.00	781.33
615	2023259019898	08/15/23 - 08/15/23	09/25/23	0.00	3,812.00	0.00	0.00	0.00
615	2023259019898	08/15/23 - 08/15/23	09/25/23	3,812.00	0.00	0.00	0.00	850.41
615	2023263016202	08/17/23 - 08/17/23	09/25/23	0.00	3,812.00	0.00	0.00	0.00
615	2023263016202	08/17/23 - 08/17/23	09/25/23	3,812.00	0.00	0.00	0.00	850.41
615	2023269018421	08/23/23 - 08/23/23	10/02/23	0.00	3,812.00	0.00	0.00	0.00
615	2023269018421	08/23/23 - 08/23/23	10/02/23	3,812.00	0.00	0.00	0.00	850.41
615	2223269008757	03/31/23 - 03/31/23	10/02/23	0.00	3,812.00	0.00	0.00	0.00
615	2223269008757	03/31/23 - 03/31/23	10/02/23	3,812.00	0.00	0.00	0.00	850.41
780	2023292085050	04/25/23 - 04/25/23	10/23/23	38.00	0.00	0.00	0.00	20.52
615	2024132015617	10/24/22 - 10/24/22	05/20/24	0.00	2,296.00	0.00	0.00	0.00
615	2024132015617	10/24/22 - 10/24/22	05/20/24	0.00	3,812.00	0.00	0.00	0.00
615	2024170029950	05/31/23 - 05/31/23	06/24/24	3,812.00	0.00	0.00	0.00	850.41
615	2024170029950	05/31/23 - 05/31/23	06/24/24	3,812.00	0.00	0.00	0.00	850.41
TOTAL				263,806.00	86,279.00	0.00	6.09	57,496.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,562,799.72	ADJUSTMENTS	0.00
COVERED CHARGES	888,424.35	CONTRACTUAL ALLOW	727,466.17
NON-COVERD CHARGES	674,375.37	TOTAL MEDICAID LIAB	160,958.18
		LESS: COB	160,958.18
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 255

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,703.19	9,882.90
MED/SURG SUPPLY	11,746.62	2,860.42
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,894.00	11,770.00
CT SCAN	15,416.00	42,043.00
PHYSICAL THERAPY	0.00	599.00
EKG/ECG	16,932.00	2,856.00
IV THERAPY	65,540.00	828.00
OPERATING ROOM	60,673.00	73,497.00
LABOR/DELIVERY ROOM	936.00	347.00
RESPIRATORY SERVICES	3,607.00	9,171.00
ANESTHESIA	34,982.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	146,243.00	408.00
RECOVERY ROOM	23,728.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	19,911.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,053.00
RENAL DIALYSIS	0.00	1,826.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	108.00	108.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,231.00	23,685.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	49,414.00	2,606.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	3,936.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,542.00	27,307.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	91,737.00	10,960.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,524.00	1,881.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,020.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	185,780.00	23,221.00
MRI SERVICES	0.00	3,812.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	84,361.02	416,398.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	263.52	1,299.26
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	152.00	0.00

TOTAL ANCILLARY	888,424.35	674,375.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	888,424.35	674,375.37

EMORY UNIVERSITY HOSPITAL MIDTOWN
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ATLANTA,GA 30308-2247

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SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2023070018035	02/22/23 - 02/22/23	03/20/23	38.00	0.00	0.00	20.52	0.00
780	2023107052168	03/31/23 - 03/31/23	04/24/23	38.00	0.00	0.00	20.52	0.00
780	2023130082771	04/18/23 - 04/18/23	05/15/23	38.00	0.00	0.00	109.79	0.00
780	2023142051298	05/02/23 - 05/02/23	05/29/23	38.00	0.00	0.00	20.52	0.00
TOTAL				152.00	0.00	0.00	171.35	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,298,131.18	ADJUSTMENTS	537.04
COVERED CHARGES	1,205,176.31	CONTRACTUAL ALLOW	1,162,951.54
NON-COVERD CHARGES	92,954.87	TOTAL MEDICAID LIAB	42,224.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	42,224.77

TOTAL NUMBER OF CLAIMS 629

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	617.68	2,401.14
MED/SURG SUPPLY	2,227.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,622.00	10,652.00
CT SCAN	71,472.00	30,986.00
PHYSICAL THERAPY	0.00	417.00
EKG/ECG	39,372.00	408.00
IV THERAPY	35,346.00	0.00
OPERATING ROOM	2,312.00	849.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,007.00	1,087.00
ANESTHESIA	240.00	0.00
GI SERVICES	963.00	0.00
EMERGENCY ROOM	766,020.00	2,650.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	835.00	4,458.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	108.00	108.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,704.00	6,336.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,506.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	5,404.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,948.00	30.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,167.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	196,910.00	16,591.00
MRI SERVICES	0.00	7,624.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	527.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,272.13	2,711.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	242.06
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,205,176.31	92,954.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,205,176.31	92,954.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,748.40	ADJUSTMENTS	0.00
COVERED CHARGES	49,353.80	CONTRACTUAL ALLOW	48,011.20
NON-COVERD CHARGES	7,394.60	TOTAL MEDICAID LIAB	1,342.60
		LESS: COB	1,342.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.96	546.42
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,194.00	0.00
CT SCAN	1,289.00	1,289.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,020.00	408.00
IV THERAPY	4,275.00	0.00
OPERATING ROOM	1,217.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	331.00	620.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,251.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,444.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,244.00	536.00
MRI SERVICES	0.00	3,812.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	138.84	183.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	49,353.80	7,394.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,353.80	7,394.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,881,323.92	ADJUSTMENTS	450,682.43
COVERED CHARGES	6,412,677.62	CONTRACTUAL ALLOW	4,674,770.78
NON-COVERD CHARGES	468,646.30	TOTAL MEDICAID LIAB	1,737,906.84
		LESS: COB	4,625.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,733,281.47

TOTAL NUMBER OF CLAIMS 281

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,293.96	5,967.58
MED/SURG SUPPLY	88,817.09	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,172.00	9,062.00
CT SCAN	0.00	2,169.00
PHYSICAL THERAPY	0.00	1,512.00
EKG/ECG	1,020.00	0.00
IV THERAPY	204,012.00	7,408.00
OPERATING ROOM	1,022,022.40	206,629.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,808.00	3,556.00
ANESTHESIA	263,866.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,419.00	0.00
RECOVERY ROOM	114,731.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	161,338.00	0.00
OCCUPATIONAL THERAPY	0.00	1,120.00
SPEECH PATHOLOGY	0.00	799.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,136.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,083.00	3,933.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,401.00	964.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	16,418.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,758.00	46,218.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	200,369.00	15,776.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,993,120.84	105,760.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	90,429.33	41,353.66
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,412,677.62	468,646.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,412,677.62	468,646.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	124,825.25	ADJUSTMENTS	0.00
COVERED CHARGES	123,139.25	CONTRACTUAL ALLOW	117,080.85
NON-COVERD CHARGES	1,686.00	TOTAL MEDICAID LIAB	6,058.40
		LESS: COB	6,058.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,254.00	120.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	110,591.25	0.00
RADIOLOGY THERAPEUTIC	8,294.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,566.00			

TOTAL ANCILLARY	123,139.25	1,686.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,139.25	1,686.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,837,091.07	ADJUSTMENTS	25,066.57
COVERED CHARGES	6,741,336.31	CONTRACTUAL ALLOW	4,593,296.41
NON-COVERD CHARGES	95,754.76	TOTAL MEDICAID LIAB	2,148,039.90
		LESS: COB	44,676.14
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	5,000.00
		REIMBURSEMENT	2,108,363.76

TOTAL NUMBER OF ADMISSIONS 258

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	901	0	769,130.00	0.00
ROUTINE NURSERY	20	0	21,640.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	125.00
TOTAL ROUTINE	921	0	790,770.00	125.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	398	0	708,100.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	398	0	708,100.00	0.00
TOTAL ACCOMODATIONS	1,319	0	1,498,870.00	125.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,073,426.95	0.00
MED/SURG SUPPLY	138,270.86	5,973.06
LABORATORY-GENERAL	1,263,704.98	0.00
RADIOLOGY-DIAGNOSTIC	100,565.07	0.00
CT SCAN	558,409.04	28,928.70
PHYSICAL THERAPY	92,403.38	0.00
EKG/ECG	48,722.38	0.00
IV THERAPY	178,972.30	0.00
OPERATING ROOM	382,623.11	1,226.89
LABOR/DELIVERY ROOM	29,796.70	0.00
RESPIRATORY SERVICES	613,921.06	0.00
ANESTHESIA	41,169.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	253,207.00	0.00
RECOVERY ROOM	26,934.60	0.00
LABORATORY PATHOLOGIC	9,348.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,265.90	0.00
SPEECH PATHOLOGY	20,075.51	0.00
RENAL DIALYSIS	43,800.12	4,156.92
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	560.00	2,262.66
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,770.96	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	29,943.76	12,486.86
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,562.84	652.38
AUDIOLOGY	1,903.84	0.00
CARDIOLOGY	70,333.28	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,832.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	39,897.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,394.14	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	328.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	62,333.99	0.01
PROFESSIONAL FEES	0.00	2,589.42
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	21,880.80
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31,461.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	2.06
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	52,290.07	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	15,237.68	15,470.00

TOTAL ANCILLARY	5,242,466.31	95,629.76
TOTAL ACCOMODATIONS	1,498,870.00	125.00
TOTAL CHARGES	6,741,336.31	95,754.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022222052808	07/26/22 - 07/29/22	08/15/22	0.00	630.00	0.00	0.00	0.00
780	2022222052836	07/18/22 - 08/04/22	08/15/22	0.00	1,530.00	0.00	0.00	0.00
780	2222227000370	07/29/22 - 08/04/22	08/22/22	0.00	630.00	0.00	0.00	0.00
780	2222236009972	07/24/22 - 07/29/22	08/29/22	0.00	540.00	0.00	0.00	0.00
780	2222249001454	08/06/22 - 08/08/22	09/19/22	0.00	270.00	0.00	0.00	0.00
780	2222256007774	07/11/22 - 07/20/22	09/19/22	0.00	360.00	0.00	0.00	0.00
780	2222263006503	08/17/22 - 08/22/22	09/26/22	0.00	990.00	0.00	0.00	0.00
780	2222263006539	08/18/22 - 08/20/22	09/26/22	0.00	65.00	0.00	0.00	0.00
780	2222263006608	08/21/22 - 08/23/22	09/26/22	0.00	270.00	0.00	0.00	0.00
780	2222272006971	09/02/22 - 09/09/22	10/03/22	0.00	540.00	0.00	0.00	0.00
780	2222279006347	09/05/22 - 09/06/22	10/10/22	0.00	180.00	0.00	0.00	0.00
780	2222279006794	09/12/22 - 09/14/22	10/17/22	0.00	360.00	0.00	0.00	0.00
614	2222284007204	09/02/22 - 09/05/22	10/17/22	3,650.04	0.00	0.00	0.00	0.00
780	2022292019376	10/10/22 - 10/12/22	10/24/22	0.00	180.00	0.00	0.00	0.00
780	2022313068376	11/01/22 - 11/02/22	11/21/22	0.00	270.00	0.00	0.00	0.00
780	5922321000451	08/02/22 - 08/09/22	11/21/22	0.00	900.00	0.00	0.00	0.00
780	2022322070231	10/06/22 - 10/17/22	11/21/22	0.00	270.00	0.00	0.00	0.00
780	2022325021927	11/10/22 - 11/13/22	11/28/22	0.00	630.00	0.00	0.00	0.00
780	2022325021928	11/12/22 - 11/15/22	11/28/22	0.00	270.00	0.00	0.00	0.00
780	2222327001916	10/10/22 - 10/12/22	12/05/22	0.00	450.00	0.00	0.00	0.00
780	2222327001948	10/21/22 - 10/22/22	11/28/22	0.00	270.00	0.00	0.00	0.00
780	2222327001979	10/21/22 - 10/23/22	12/05/22	0.00	180.00	0.00	0.00	0.00
780	2022332024598	11/17/22 - 11/19/22	12/05/22	0.00	270.00	0.00	0.00	0.00
780	2022332024601	11/11/22 - 11/20/22	12/05/22	0.00	1,440.00	0.00	0.00	0.00
780	2022335080624	11/23/22 - 11/25/22	12/05/22	0.00	90.00	0.00	0.00	0.00
780	2022346023513	11/09/22 - 11/12/22	12/19/22	0.00	270.00	0.00	0.00	0.00
780	2022348049515	11/05/22 - 11/14/22	12/19/22	0.00	630.00	0.00	0.00	0.00
780	2222350013230	09/21/22 - 09/23/22	12/19/22	0.00	90.00	0.00	0.00	0.00
614	2022362039081	10/26/22 - 11/11/22	01/02/23	3,968.80	0.00	0.00	0.00	0.00
780	2022362039081	10/26/22 - 11/11/22	01/02/23	0.00	900.00	0.00	0.00	0.00
614	2223005009498	11/30/22 - 12/02/22	01/09/23	3,650.04	0.00	0.00	0.00	0.00
780	2323028000011	10/04/22 - 10/14/22	02/06/23	0.00	180.00	0.00	1,460.39	0.00
780	2223052004320	08/15/22 - 08/19/22	02/27/23	0.00	360.00	0.00	0.00	0.00
614	2023058021654	02/16/23 - 02/19/23	03/06/23	3,968.80	0.00	0.00	0.00	0.00
780	2223066004647	09/07/22 - 09/09/22	03/13/23	0.00	270.00	0.00	0.00	0.00
780	2023077028976	08/11/22 - 08/18/22	03/27/23	0.00	540.00	0.00	0.00	0.00
780	2223222001881	02/08/23 - 03/18/23	08/14/23	0.00	65.00	0.00	0.00	0.00
780	2223222001980	05/11/23 - 06/22/23	08/14/23	0.00	65.00	0.00	0.00	0.00
780	2323260000007	11/09/22 - 11/16/22	09/25/23	0.00	360.00	0.00	1,255.05	0.00
780	2023296032038	09/10/22 - 09/14/22	10/30/23	0.00	90.00	0.00	0.00	0.00
780	2024044055762	01/05/23 - 01/09/23	02/19/24	0.00	65.00	0.00	0.00	0.00

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

TOTAL	15,237.68	15,470.00	0.00	2,715.44	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,953,838.24	ADJUSTMENTS	357,170.80
COVERED CHARGES	5,884,791.76	CONTRACTUAL ALLOW	4,718,106.16
NON-COVERD CHARGES	1,069,046.48	TOTAL MEDICAID LIAB	1,166,685.60
		LESS: COB	2,242.55
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,164,443.05
		ALL OTHER	953,766.64
		FEE SCHEDULE-LAB	128,923.27
		INJECTABLE DRUGS	81,753.14

TOTAL NUMBER OF CLAIMS 2,945

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,860.75	9,801.07
MED/SURG SUPPLY	96,230.69	33,081.51
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	172,266.35	16,219.40
CT SCAN	927,283.63	174,188.08
PHYSICAL THERAPY	60,515.66	5,608.23
EKG/ECG	54,014.14	5,289.90
IV THERAPY	396,224.59	10,459.31
OPERATING ROOM	714,903.59	184,922.31
LABOR/DELIVERY ROOM	2,787.19	223.58
RESPIRATORY SERVICES	37,702.00	24,475.24
ANESTHESIA	96,753.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	517,919.70	4,433.96
RECOVERY ROOM	47,731.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	15,100.85	0.00
OCCUPATIONAL THERAPY	0.00	373.50
SPEECH PATHOLOGY	0.00	1,640.70
RENAL DIALYSIS	0.00	1,192.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	342,112.61	64,444.49
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	113,482.51	8,819.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,563.51	1,258.76
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	68,858.27	37,833.60
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30,578.84	20,535.03
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,374.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	35,260.37	1,338.01

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	128,049.87	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	410.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,187,210.35	133,699.34
MRI SERVICES	122,445.15	6,177.41
PROFESSIONAL FEES	0.00	144.58
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	597,964.36	245,641.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	13,448.00	76,835.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	24,150.28	0.00

TOTAL ANCILLARY	5,884,791.76	1,069,046.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,884,791.76	1,069,046.48

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022196063235	07/08/22 - 07/08/22	07/25/22	65.00	0.00	0.00	0.00	20.52
780	2022238069153	08/14/22 - 08/14/22	08/29/22	65.00	0.00	0.00	0.00	20.52
614	2022242048189	08/17/22 - 08/17/22	09/05/22	3,968.80	0.00	0.00	0.00	881.84
614	2222266011781	07/11/22 - 07/11/22	09/26/22	3,968.80	0.00	0.00	0.00	930.68
780	2022266084312	09/09/22 - 09/09/22	09/26/22	65.00	0.00	0.00	0.00	20.52
780	2022311035169	10/24/22 - 10/24/22	11/14/22	65.00	0.00	0.00	0.00	20.52
780	2022314082741	10/31/22 - 10/31/22	11/14/22	65.00	0.00	0.00	0.00	20.52
614	2022350070447	12/01/22 - 12/01/22	12/19/22	3,650.04	0.00	0.00	0.00	855.94
780	2023027072783	01/12/23 - 01/12/23	01/30/23	65.00	0.00	0.00	0.00	20.52
780	2023039045833	01/24/23 - 01/24/23	02/13/23	65.00	0.00	0.00	0.00	20.52
780	2023044025619	01/26/23 - 01/26/23	02/20/23	65.00	0.00	0.00	0.00	20.52
780	2023046056516	01/02/23 - 01/02/23	02/20/23	65.00	0.00	0.00	0.00	20.52
780	2023052053377	02/06/23 - 02/06/23	02/27/23	65.00	0.00	0.00	0.00	20.52
614	2223058002484	02/03/23 - 02/03/23	03/06/23	3,650.04	0.00	0.00	0.00	855.94
614	2023126030163	04/19/23 - 04/19/23	05/15/23	3,968.80	0.00	0.00	0.00	930.68
780	2023131076546	05/01/23 - 05/01/23	05/15/23	65.00	0.00	0.00	0.00	20.52
780	2023136068046	03/04/23 - 03/04/23	05/22/23	65.00	0.00	0.00	0.00	20.52
780	2023136068046	03/06/23 - 03/06/23	05/22/23	65.00	0.00	0.00	0.00	20.52
780	5923166001001	05/21/23 - 05/21/23	06/19/23	65.00	0.00	0.00	0.00	20.52
780	5923166001001	05/22/23 - 05/22/23	06/19/23	65.00	0.00	0.00	0.00	20.52
614	2023200062533	06/29/23 - 06/29/23	07/24/23	3,968.80	0.00	0.00	0.00	930.68
TOTAL				24,150.28	0.00	0.00	0.00	5,693.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,104.77	ADJUSTMENTS	0.00
COVERED CHARGES	52,480.22	CONTRACTUAL ALLOW	43,149.21
NON-COVERD CHARGES	27,624.55	TOTAL MEDICAID LIAB	9,331.01
		LESS: COB	9,331.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 44

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.84	0.00
MED/SURG SUPPLY	222.14	3.44
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,166.67	183.17
CT SCAN	4,525.61	21,643.03
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	593.56	0.00
IV THERAPY	5,749.64	0.00
OPERATING ROOM	1,349.58	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,865.25	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	238.17	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,151.24	1,341.41
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	2,729.09
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	408.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,064.98	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,814.33	1,582.12
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,234.11	142.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	52,480.22	27,624.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,480.22	27,624.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	229,067.53	ADJUSTMENTS	939.84
COVERED CHARGES	204,260.90	CONTRACTUAL ALLOW	191,808.02
NON-COVERD CHARGES	24,806.63	TOTAL MEDICAID LIAB	12,452.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,452.88

TOTAL NUMBER OF CLAIMS 159

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,324.55	316.52
MED/SURG SUPPLY	2,824.26	809.62
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,462.97	980.22
CT SCAN	47,742.69	8,794.31
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,084.24	150.52
IV THERAPY	20,977.39	0.00
OPERATING ROOM	0.00	7,562.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	231.61	0.00
ANESTHESIA	772.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	65,396.53	0.00
RECOVERY ROOM	679.80	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 SERVICE	616.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,942.76	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,324.80	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/OBSERV. RM	840.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	555.23	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	82.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	39,008.52	4,600.58
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,411.55	1,108.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	401.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	65.00	0.00

TOTAL ANCILLARY	204,260.90	24,806.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	204,260.90	24,806.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022213039290	07/21/22 - 07/21/22	08/08/22	65.00	0.00	0.00	0.00	0.00
TOTAL				65.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,147.52	ADJUSTMENTS	0.00
COVERED CHARGES	7,513.76	CONTRACTUAL ALLOW	7,200.48
NON-COVERD CHARGES	9,633.76	TOTAL MEDICAID LIAB	313.28
		LESS: COB	313.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17.85	0.00
MED/SURG SUPPLY	82.44	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	9,137.35
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,630.59	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,915.71	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	420.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,859.39	310.58
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	587.78	185.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,513.76	9,633.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,513.76	9,633.76

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	922,839.67	ADJUSTMENTS	89,767.56
COVERED CHARGES	918,855.31	CONTRACTUAL ALLOW	823,477.24
NON-COVERD CHARGES	3,984.36	TOTAL MEDICAID LIAB	95,378.07
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	95,378.07

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	748.11	15.00
MED/SURG SUPPLY	4,233.43	142.88
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201.37	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	148.19	0.00
OPERATING ROOM	42,350.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,862.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,359.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,578.14	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	26,472.19	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,557.80	205.72
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	829,103.98	180.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	240.00	3,440.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	918,855.31	3,984.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	918,855.31	3,984.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,405,766.75	ADJUSTMENTS	1,415,626.60
COVERED CHARGES	8,394,785.67	CONTRACTUAL ALLOW	6,419,876.54
NON-COVERD CHARGES	10,981.08	TOTAL MEDICAID LIAB	1,974,909.13
		LESS: COB	13,567.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,961,341.74

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	993	0	2,163,300.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	993	0	2,163,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	84	0	403,014.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	84	0	403,014.00	0.00
TOTAL ACCOMODATIONS	1,077	0	2,566,314.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255,491.57	0.00
MED/SURG SUPPLY	143,123.03	679.08
LABORATORY-GENERAL	594,672.35	0.00
RADIOLOGY-DIAGNOSTIC	29,957.00	0.00
CT SCAN	26,670.00	0.00
PHYSICAL THERAPY	187,880.00	0.00
EKG/ECG	8,116.00	0.00
IV THERAPY	746.00	0.00
OPERATING ROOM	11,869.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,745,993.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,954.00	0.00
EMERGENCY ROOM	8,098.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	206,449.00	0.00
SPEECH PATHOLOGY	133,165.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,528.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,671.00	6,475.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	39,967.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,312.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	48,473.00	3,827.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	15,048.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,812.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	332,459.27	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	6,016.75	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,828,471.67	10,981.08
TOTAL ACCOMODATIONS	2,566,314.00	0.00
TOTAL CHARGES	8,394,785.67	10,981.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,782,324.24	ADJUSTMENTS	1,793,265.02
COVERED CHARGES	47,312,117.22	CONTRACTUAL ALLOW	37,947,978.69
NON-COVERD CHARGES	470,207.02	TOTAL MEDICAID LIAB	9,364,138.53
		LESS: COB	136,884.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,227,254.36

TOTAL NUMBER OF ADMISSIONS 928

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,647	0	9,360,554.00	0.00
ROUTINE NURSERY	995	0	3,101,144.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,642	0	12,461,698.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	992	0	6,389,387.00	0.00
NICU	16	0	116,480.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,008	0	6,505,867.00	0.00
TOTAL ACCOMODATIONS	6,650	0	18,967,565.00	0.00

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,826,450.79	0.00
MED/SURG SUPPLY	695,380.72	0.00
LABORATORY-GENERAL	5,153,672.68	104.00
RADIOLOGY-DIAGNOSTIC	446,368.00	0.00
CT SCAN	1,417,225.00	119,346.00
PHYSICAL THERAPY	793,032.00	0.00
EKG/ECG	215,411.00	0.00
IV THERAPY	177,877.00	0.00
OPERATING ROOM	2,655,866.60	0.00
LABOR/DELIVERY ROOM	399,107.00	32,702.00
RESPIRATORY SERVICES	3,303,249.00	0.00
ANESTHESIA	554,168.00	0.00
GI SERVICES	145,911.00	0.00
EMERGENCY ROOM	1,865,201.00	0.00
RECOVERY ROOM	317,617.00	0.00
LABORATORY PATHOLOGIC	124,820.00	0.00
RADIOLOGY THERAPEUTIC	38,712.00	0.00
OCCUPATIONAL THERAPY	664,499.00	0.00
SPEECH PATHOLOGY	241,091.00	0.00
RENAL DIALYSIS	514,021.00	44,593.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,611.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	240,070.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	206,920.00	183,890.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	78,971.00	10,427.80
AUDIOLOGY	80,362.00	0.00
CARDIOLOGY	2,102,398.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	73,720.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	901,264.00	33,998.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	285,041.00	0.00
RECREATIONAL THERAPY	40,545.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	323,878.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	45,146.22
INJECTABLE DRUGS	1,157,675.36	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	247,541.07	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	45,876.00	0.00

TOTAL ANCILLARY	28,344,552.22	470,207.02
TOTAL ACCOMODATIONS	18,967,565.00	0.00
TOTAL CHARGES	47,312,117.22	470,207.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2222349010862	11/21/22 - 11/26/22	12/19/22	4,592.00	0.00	0.00	0.00	0.00
614	5923005001826	11/27/22 - 12/18/22	01/09/23	2,296.00	0.00	0.00	0.00	0.00
614	5223011070479	11/15/22 - 11/23/22	01/16/23	2,296.00	0.00	0.00	0.00	0.00
614	2223013012586	11/11/22 - 11/15/22	01/16/23	6,888.00	0.00	0.00	0.00	0.00
614	2223039005721	10/17/22 - 11/04/22	02/13/23	4,592.00	0.00	0.00	0.00	0.00
615	2023061111961	01/18/23 - 02/17/23	03/06/23	2,296.00	0.00	0.00	0.00	0.00
614	5923089001543	01/13/23 - 01/19/23	04/03/23	2,296.00	0.00	0.00	0.00	0.00
614	5923102001322	03/16/23 - 03/26/23	04/17/23	3,812.00	0.00	0.00	0.00	0.00
615	2023110124520	04/13/23 - 04/17/23	04/24/23	2,296.00	0.00	0.00	0.00	0.00
614	2023114042899	02/17/23 - 02/23/23	05/01/23	2,296.00	0.00	0.00	0.00	0.00
614	5923114001252	02/26/23 - 03/03/23	05/01/23	3,812.00	0.00	0.00	0.00	0.00
615	2023160115116	12/26/22 - 12/29/22	06/19/23	2,296.00	0.00	0.00	0.00	0.00
615	2023208110235	07/09/23 - 07/11/23	07/31/23	3,812.00	0.00	0.00	0.00	0.00
615	2223255004643	07/22/23 - 07/28/23	09/18/23	2,296.00	0.00	0.00	0.00	0.00
TOTAL				45,876.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,040,394.79	ADJUSTMENTS	0.00
COVERED CHARGES	2,022,382.22	CONTRACTUAL ALLOW	1,833,365.20
NON-COVERD CHARGES	18,012.57	TOTAL MEDICAID LIAB	189,017.02
		LESS: COB	189,017.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	77	0	137,332.00	0.00
ROUTINE NURSERY	143	0	522,276.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	220	0	659,608.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	16	0	113,976.00	0.00
NICU	41	0	298,480.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	57	0	412,456.00	0.00
TOTAL ACCOMODATIONS	277	0	1,072,064.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,283.95	0.00
MED/SURG SUPPLY	30,713.15	0.00
LABORATORY-GENERAL	155,532.00	0.00
RADIOLOGY-DIAGNOSTIC	13,679.00	0.00
CT SCAN	13,126.00	5,709.00
PHYSICAL THERAPY	24,860.00	0.00
EKG/ECG	2,448.00	0.00
IV THERAPY	3,336.00	0.00
OPERATING ROOM	25,441.00	0.00
LABOR/DELIVERY ROOM	155,849.00	0.00
RESPIRATORY SERVICES	221,156.00	0.00
ANESTHESIA	38,268.00	0.00
GI SERVICES	1,879.00	0.00
EMERGENCY ROOM	39,326.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	4,318.00	0.00
RADIOLOGY THERAPEUTIC	5,449.00	0.00
OCCUPATIONAL THERAPY	2,159.00	0.00
SPEECH PATHOLOGY	7,225.00	0.00
RENAL DIALYSIS	7,130.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,250.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,984.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,303.00	11,655.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,585.00	0.00
CARDIOLOGY	69,478.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,555.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	648.57
INJECTABLE DRUGS	22,297.91	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,806.21	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	950,318.22	18,012.57
TOTAL ACCOMODATIONS	1,072,064.00	0.00
TOTAL CHARGES	2,022,382.22	18,012.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,211,194.79	ADJUSTMENTS	207,865.85
COVERED CHARGES	12,471,060.92	CONTRACTUAL ALLOW	10,357,989.61
NON-COVERD CHARGES	2,740,133.87	TOTAL MEDICAID LIAB	2,113,071.31
		LESS: COB	10,550.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,102,520.40
		ALL OTHER	1,864,852.23
		FEE SCHEDULE-LAB	152,479.63
		INJECTABLE DRUGS	85,188.54

TOTAL NUMBER OF CLAIMS 4,288

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,806.49	154,302.19
MED/SURG SUPPLY	188,348.55	176.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	442,871.00	92,552.00
CT SCAN	1,126,006.00	477,020.00
PHYSICAL THERAPY	164,819.00	27,336.00
EKG/ECG	273,828.00	5,050.00
IV THERAPY	259,723.00	19,811.00
OPERATING ROOM	870,351.90	482,691.10
LABOR/DELIVERY ROOM	7,020.00	936.00
RESPIRATORY SERVICES	79,708.00	13,010.00
ANESTHESIA	329,637.00	0.00
GI SERVICES	168,193.00	79,584.00
EMERGENCY ROOM	4,029,480.00	48,222.00
RECOVERY ROOM	362,575.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	141,579.50	110,594.00
OCCUPATIONAL THERAPY	57,699.00	27,309.00
SPEECH PATHOLOGY	11,402.00	12,259.00
RENAL DIALYSIS	0.00	68,248.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	784.00	2,700.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	313,236.00	120,202.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	62,867.00	2,606.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	81,429.00	99,300.19
AUDIOLOGY	0.00	0.00
CARDIOLOGY	486,615.50	310,684.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	51,128.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	512,072.46	18,040.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	251,964.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	404.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,745,929.70	200,790.00
MRI SERVICES	87,072.00	27,508.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,779.56
INJECTABLE DRUGS	193,284.95	155,280.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	50,682.87	176,146.85
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	22,948.00	4,592.00

TOTAL ANCILLARY	12,471,060.92	2,740,133.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,471,060.92	2,740,133.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022286015083	10/08/22 - 10/08/22	10/17/22	3,812.00	0.00	0.00	0.00	659.78
614	2022351011626	12/12/22 - 12/12/22	12/26/22	3,812.00	0.00	0.00	0.00	659.78
614	2023034097864	01/31/23 - 01/31/23	02/13/23	3,812.00	0.00	0.00	0.00	659.78
614	2023034097864	01/31/23 - 01/31/23	02/13/23	3,812.00	0.00	0.00	0.00	659.78
614	2023048087935	02/14/23 - 02/14/23	02/27/23	0.00	2,296.00	0.00	0.00	0.00
614	2023062085556	02/21/23 - 02/21/23	03/13/23	3,812.00	0.00	0.00	0.00	659.78
614	2023062085794	02/28/23 - 02/28/23	03/13/23	3,812.00	0.00	0.00	0.00	659.78
614	5923095000415	03/17/23 - 03/17/23	04/10/23	0.00	2,296.00	0.00	0.00	0.00
780	2023110129211	04/10/23 - 04/10/23	04/24/23	38.00	0.00	0.00	0.00	20.52
780	2023114042405	03/31/23 - 03/31/23	05/01/23	38.00	0.00	0.00	0.00	20.52
TOTAL				22,948.00	4,592.00	0.00	0.00	3,999.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	296,346.16	ADJUSTMENTS	0.00
COVERED CHARGES	204,069.01	CONTRACTUAL ALLOW	169,661.16
NON-COVERD CHARGES	92,277.15	TOTAL MEDICAID LIAB	34,407.85
		LESS: COB	34,407.85
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,226.26	2,257.26
MED/SURG SUPPLY	4,158.90	458.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,764.00	1,378.00
CT SCAN	12,764.00	23,010.00
PHYSICAL THERAPY	0.00	417.00
EKG/ECG	2,448.00	204.00
IV THERAPY	2,691.00	0.00
OPERATING ROOM	0.00	30,483.00
LABOR/DELIVERY ROOM	624.00	312.00
RESPIRATORY SERVICES	568.00	1,240.00
ANESTHESIA	11,089.00	0.00
GI SERVICES	3,201.00	0.00
EMERGENCY ROOM	71,195.00	408.00
RECOVERY ROOM	8,164.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	712.00
SPEECH PATHOLOGY	0.00	597.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,629.00	4,561.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,201.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,128.00	540.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,469.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,296.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,777.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,093.00	11,537.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,147.85	372.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,435.00	13,789.61
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	204,069.01	92,277.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	204,069.01	92,277.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	992,670.37	ADJUSTMENTS	335.65
COVERED CHARGES	900,883.61	CONTRACTUAL ALLOW	872,420.49
NON-COVERD CHARGES	91,786.76	TOTAL MEDICAID LIAB	28,463.12
		LESS: COB	61.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	28,401.44

TOTAL NUMBER OF CLAIMS 424

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	429.89	6,330.54
MED/SURG SUPPLY	1,121.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,761.00	9,032.00
CT SCAN	80,099.00	37,146.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	21,728.00	0.00
IV THERAPY	16,457.00	0.00
OPERATING ROOM	2,130.00	0.00
LABOR/DELIVERY ROOM	1,404.00	1,404.00
RESPIRATORY SERVICES	1,103.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	533,625.00	1,533.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	533.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	20,250.00	11,929.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,449.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,489.00	3,497.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,256.00	30.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,286.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	162,047.00	13,799.00
MRI SERVICES	0.00	2,296.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,248.72	4,257.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	900,883.61	91,786.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	900,883.61	91,786.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,778.68	ADJUSTMENTS	0.00
COVERED CHARGES	40,763.64	CONTRACTUAL ALLOW	39,756.69
NON-COVERD CHARGES	17,015.04	TOTAL MEDICAID LIAB	1,006.95
		LESS: COB	1,006.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	2,621.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,007.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,838.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,533.00	714.00
EKG/ECG	816.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	864.00	408.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	312.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,857.00	858.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120.64	298.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	810.00	780.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,208.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	782.00	5,128.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,824.00	0.00			

TOTAL ANCILLARY	40,763.64	17,015.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,763.64	17,015.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	943,563.36	ADJUSTMENTS	31,836.30
COVERED CHARGES	783,802.57	CONTRACTUAL ALLOW	656,423.98
NON-COVERD CHARGES	159,760.79	TOTAL MEDICAID LIAB	127,378.59
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	127,378.59

TOTAL NUMBER OF CLAIMS 24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,131.93	3,714.35
MED/SURG SUPPLY	36,756.12	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,893.00	235.00
CT SCAN	0.00	2,293.00
PHYSICAL THERAPY	0.00	8,098.00
EKG/ECG	1,428.00	0.00
IV THERAPY	1,308.00	0.00
OPERATING ROOM	335,769.98	40,201.02
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,254.00	1,087.00
ANESTHESIA	86,493.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,514.00	0.00
RECOVERY ROOM	107,543.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,560.00	0.00
OCCUPATIONAL THERAPY	0.00	8,377.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	780.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,906.00	1,295.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	73,686.00	25,505.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,058.00	544.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,033.00	3,783.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	57,116.25	5,111.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,691.29	59,516.81
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	783,802.57	159,760.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	783,802.57	159,760.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,244,191.64	ADJUSTMENTS	460,199.98
COVERED CHARGES	17,957,584.59	CONTRACTUAL ALLOW	13,408,573.56
NON-COVERD CHARGES	286,607.05	TOTAL MEDICAID LIAB	4,549,011.03
		LESS: COB	47,227.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,501,783.83

TOTAL NUMBER OF ADMISSIONS 482

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,233	0	4,166,169.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,233	0	4,166,169.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	270	0	2,067,031.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	270	0	2,067,031.00	0.00
TOTAL ACCOMODATIONS	2,503	0	6,233,200.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,092,157.28	0.00
MED/SURG SUPPLY	307,046.10	0.00
LABORATORY-GENERAL	2,605,662.05	0.00
RADIOLOGY-DIAGNOSTIC	149,681.00	0.00
CT SCAN	877,410.00	12,607.00
PHYSICAL THERAPY	132,862.00	0.00
EKG/ECG	151,932.00	0.00
IV THERAPY	155,083.00	0.00
OPERATING ROOM	645,412.00	3,993.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,341,501.00	0.00
ANESTHESIA	94,056.00	0.00
GI SERVICES	24,303.00	0.00
EMERGENCY ROOM	1,450,187.00	0.00
RECOVERY ROOM	31,446.00	0.00
LABORATORY PATHOLOGIC	11,560.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	98,811.00	0.00
SPEECH PATHOLOGY	40,096.00	0.00
RENAL DIALYSIS	258,039.00	16,242.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	648.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	127,030.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	157,176.00	139,860.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	76,377.00	21,213.40
AUDIOLOGY	0.00	0.00
CARDIOLOGY	781,404.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,843.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	396,393.00	31,896.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	151,689.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	53,500.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	60,795.65
INJECTABLE DRUGS	431,308.79	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	39,075.37	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	23,696.00	0.00

TOTAL ANCILLARY	11,724,384.59	286,607.05
TOTAL ACCOMODATIONS	6,233,200.00	0.00
TOTAL CHARGES	17,957,584.59	286,607.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022334079529	11/06/22 - 11/12/22	12/05/22	2,296.00	0.00	0.00	0.00	0.00
614	2023058043740	01/30/23 - 02/14/23	03/06/23	2,296.00	0.00	0.00	0.00	0.00
614	2023089097708	12/17/22 - 12/22/22	04/10/23	2,296.00	0.00	0.00	0.00	0.00
615	2023102089805	04/05/23 - 04/06/23	04/17/23	6,108.00	0.00	0.00	0.00	0.00
614	2023114033918	04/08/23 - 04/19/23	05/01/23	3,812.00	0.00	0.00	0.00	0.00
615	2323264000296	02/10/23 - 02/13/23	10/23/23	4,592.00	0.00	0.00	0.00	0.00
615	2024108029652	10/29/22 - 11/01/22	04/22/24	2,296.00	0.00	0.00	0.00	0.00
TOTAL				23,696.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	124,202.70	ADJUSTMENTS	0.00
COVERED CHARGES	124,202.70	CONTRACTUAL ALLOW	74,943.25
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	49,259.45
		LESS: COB	49,259.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	12	0	21,684.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	21,684.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	21,684.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,130.90	0.00
MED/SURG SUPPLY	7,197.62	0.00
LABORATORY-GENERAL	10,265.00	0.00
RADIOLOGY-DIAGNOSTIC	1,415.00	0.00
CT SCAN	8,739.00	0.00
PHYSICAL THERAPY	1,464.00	0.00
EKG/ECG	1,632.00	0.00
IV THERAPY	3,306.00	0.00
OPERATING ROOM	27,072.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	735.00	0.00
ANESTHESIA	6,479.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	14,492.00	0.00
RECOVERY ROOM	2,938.00	0.00
LABORATORY PATHOLOGIC	414.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	483.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,128.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	747.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	102,518.70	0.00
TOTAL ACCOMODATIONS	21,684.00	0.00
TOTAL CHARGES	124,202.70	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,202,410.09	ADJUSTMENTS	152,636.41
COVERED CHARGES	9,615,304.09	CONTRACTUAL ALLOW	7,796,063.89
NON-COVERD CHARGES	1,587,106.00	TOTAL MEDICAID LIAB	1,819,240.20
		LESS: COB	6,234.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,813,005.90
		ALL OTHER	1,654,829.34
		FEE SCHEDULE-LAB	142,642.36
		INJECTABLE DRUGS	15,534.20

TOTAL NUMBER OF CLAIMS 3,058

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,768.42	114,164.51
MED/SURG SUPPLY	98,483.15	352.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	317,801.00	75,215.00
CT SCAN	1,185,351.00	433,029.00
PHYSICAL THERAPY	81,426.00	14,244.00
EKG/ECG	243,560.00	3,826.00
IV THERAPY	241,394.00	31,624.00
OPERATING ROOM	270,021.00	157,221.00
LABOR/DELIVERY ROOM	624.00	0.00
RESPIRATORY SERVICES	127,921.00	9,073.00
ANESTHESIA	87,025.00	0.00
GI SERVICES	59,167.00	32,288.00
EMERGENCY ROOM	4,179,292.00	58,731.00
RECOVERY ROOM	41,490.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,939.00	11,145.00
OCCUPATIONAL THERAPY	23,859.00	15,611.00
SPEECH PATHOLOGY	1,591.00	10,274.00
RENAL DIALYSIS	0.00	92,101.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,188.00	3,355.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	286,903.00	110,268.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	37,459.00	2,590.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,272.00	34,891.34
AUDIOLOGY	0.00	0.00
CARDIOLOGY	98,913.00	111,284.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	42,433.00	1,606.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	182,653.00	10,017.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	226,015.00	3,762.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,486,007.00	125,730.00
MRI SERVICES	79,528.00	32,056.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	527.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	3,171.34	3,718.28
INJECTABLE DRUGS	81,932.83	63,136.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,214.35	19,158.43
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	20,902.00	6,108.00

TOTAL ANCILLARY	9,615,304.09	1,587,106.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,615,304.09	1,587,106.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022301093681	10/25/22 - 10/25/22	11/07/22	0.00	2,296.00	0.00	0.00	0.00
614	2222322012741	10/21/22 - 10/21/22	11/21/22	3,812.00	0.00	0.00	0.00	765.98
614	2222340001620	11/09/22 - 11/09/22	12/12/22	3,358.00	0.00	0.00	0.00	674.75
614	2022342105765	12/05/22 - 12/05/22	12/12/22	3,812.00	0.00	0.00	0.00	765.98
614	2023035018991	01/31/23 - 01/31/23	02/13/23	3,812.00	0.00	0.00	0.00	765.98
614	2023042022171	01/21/23 - 01/21/23	02/20/23	0.00	3,812.00	0.00	0.00	0.00
614	2023058051433	02/24/23 - 02/24/23	03/06/23	3,812.00	0.00	0.00	0.00	765.98
614	2023076112529	03/14/23 - 03/14/23	03/27/23	2,296.00	0.00	0.00	0.00	461.35
TOTAL				20,902.00	6,108.00	0.00	0.00	4,200.02

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	189,831.83	ADJUSTMENTS	0.00
COVERED CHARGES	133,629.50	CONTRACTUAL ALLOW	107,872.28
NON-COVERD CHARGES	56,202.33	TOTAL MEDICAID LIAB	25,757.22
		LESS: COB	25,757.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 44

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	983.28	1,739.50
MED/SURG SUPPLY	484.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,177.00	0.00
CT SCAN	9,936.00	21,619.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,040.00	0.00
IV THERAPY	3,288.00	0.00
OPERATING ROOM	0.00	10,575.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,922.00	6,491.00
ANESTHESIA	2,542.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	62,995.00	1,419.00
RECOVERY ROOM	2,080.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	6,169.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	216.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,244.00	1,796.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,900.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,762.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,824.00	1,972.00
MRI SERVICES	3,812.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,424.22	963.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	3,458.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	133,629.50	56,202.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	133,629.50	56,202.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,032,040.53	ADJUSTMENTS	604.17
COVERED CHARGES	947,650.02	CONTRACTUAL ALLOW	918,515.60
NON-COVERD CHARGES	84,390.51	TOTAL MEDICAID LIAB	29,134.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	29,134.42

TOTAL NUMBER OF CLAIMS 434

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,162.16	8,625.95
MED/SURG SUPPLY	704.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,148.00	9,643.00
CT SCAN	102,280.00	34,385.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	17,494.00	0.00
IV THERAPY	22,645.00	2,183.00
OPERATING ROOM	404.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,443.00	1,087.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	574,631.00	3,879.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,713.00	9,264.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,496.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,228.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,405.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	152,542.00	11,544.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,354.86	3,779.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	947,650.02	84,390.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	947,650.02	84,390.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,445.59	ADJUSTMENTS	0.00
COVERED CHARGES	26,886.81	CONTRACTUAL ALLOW	26,014.12
NON-COVERD CHARGES	1,558.78	TOTAL MEDICAID LIAB	872.69
		LESS: COB	872.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.65	35.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,761.00	0.00
CT SCAN	1,289.00	1,289.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	408.00	0.00
IV THERAPY	1,527.00	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	17,155.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,614.00	120.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	151.16	114.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	26,886.81	1,558.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,886.81	1,558.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,765.63	ADJUSTMENTS	12,087.10
COVERED CHARGES	95,187.52	CONTRACTUAL ALLOW	77,056.87
NON-COVERD CHARGES	8,578.11	TOTAL MEDICAID LIAB	18,130.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	18,130.65

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,628.22	910.00
MED/SURG SUPPLY	6,060.33	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,550.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,589.00
EKG/ECG	612.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	55,413.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	821.00	0.00
ANESTHESIA	12,679.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,228.00	0.00
RECOVERY ROOM	5,512.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,119.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,824.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,678.00	30.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,307.27	1,179.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	874.70	3,750.46
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	95,187.52	8,578.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	95,187.52	8,578.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	134,633,033.73	ADJUSTMENTS	2,551,872.07
COVERED CHARGES	132,701,908.03	CONTRACTUAL ALLOW	122,539,890.27
NON-COVERD CHARGES	1,931,125.70	TOTAL MEDICAID LIAB	10,162,017.76
		LESS: COB	113,737.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,898.00
		REIMBURSEMENT	10,051,178.76

TOTAL NUMBER OF ADMISSIONS 627

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,696	0	7,283,459.35	0.00
ROUTINE NURSERY	140	0	587,079.19	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,836	0	7,870,538.54	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,004	0	5,621,474.86	0.00
NICU	0	0	0.00	0.00
PED ICU	4	0	22,705.72	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	464	0	9,078,364.72	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,472	0	14,722,545.30	0.00
TOTAL ACCOMODATIONS	5,308	0	22,593,083.84	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,826,328.08	456.00
MED/SURG SUPPLY	12,169,414.14	49,610.10
LABORATORY-GENERAL	16,376,563.20	42,758.60
RADIOLOGY-DIAGNOSTIC	1,315,531.07	3,984.00
CT SCAN	2,524,207.35	732,837.22
PHYSICAL THERAPY	1,772,358.29	341.72
EKG/ECG	613,189.18	7,621.26
IV THERAPY	13,905.80	6,305.50
OPERATING ROOM	26,005,133.23	0.00
LABOR/DELIVERY ROOM	104,137.26	0.00
RESPIRATORY SERVICES	6,449,771.97	5,592.87
ANESTHESIA	53,805.72	1,494.75
GI SERVICES	327,622.09	0.00
EMERGENCY ROOM	1,300,635.95	4,725.46
RECOVERY ROOM	2,299,530.12	0.00
LABORATORY PATHOLOGIC	441,235.34	0.00
RADIOLOGY THERAPEUTIC	28,380.36	0.00
OCCUPATIONAL THERAPY	2,375,285.88	837.97
SPEECH PATHOLOGY	330,133.49	1,062.84
RENAL DIALYSIS	534,453.52	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,975.40	54,200.53
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	272,937.91	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	775,809.66	801,311.44
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	409,047.70	57,879.71
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,487,628.70	54,958.37
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,629.26	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	299,725.33	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	595,975.79	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,294.10
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	700,539.12	0.03
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,045,333.03	33,286.03
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	70,567.20
IMPL DEV CHARGE PATIENTS	599,600.25	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	110,108,824.19	1,931,125.70
TOTAL ACCOMODATIONS	22,593,083.84	0.00
TOTAL CHARGES	132,701,908.03	1,931,125.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,258,946.13	ADJUSTMENTS	0.00
COVERED CHARGES	1,231,631.92	CONTRACTUAL ALLOW	1,199,500.59
NON-COVERD CHARGES	27,314.21	TOTAL MEDICAID LIAB	32,131.33
		LESS: COB	32,194.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	32	0	67,654.78	0.00
ROUTINE NURSERY	1	0	2,024.64	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	69,679.42	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	14	0	114,779.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1	0	20,585.86	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	15	0	135,364.86	0.00
TOTAL ACCOMODATIONS	48	0	205,044.28	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,990.98	0.00
MED/SURG SUPPLY	106,285.67	0.00
LABORATORY-GENERAL	148,052.83	0.00
RADIOLOGY-DIAGNOSTIC	11,570.97	0.00
CT SCAN	0.00	8,243.90
PHYSICAL THERAPY	11,263.63	0.00
EKG/ECG	5,588.92	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	285,294.74	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	88,478.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,993.28	0.00
RECOVERY ROOM	51,131.18	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,581.06	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	200.98	513.63
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,086.25	18,556.68
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,596.66	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	10,976.39	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	228,496.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,026,587.64	27,314.21
TOTAL ACCOMODATIONS	205,044.28	0.00
TOTAL CHARGES	1,231,631.92	27,314.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,497,429.40	ADJUSTMENTS	294,319.33
COVERED CHARGES	27,990,592.61	CONTRACTUAL ALLOW	26,351,094.74
NON-COVERD CHARGES	7,506,836.79	TOTAL MEDICAID LIAB	1,639,497.87
		LESS: COB	3,212.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,636,285.64
		ALL OTHER	1,521,102.85
		FEE SCHEDULE-LAB	107,281.40
		INJECTABLE DRUGS	7,901.39

TOTAL NUMBER OF CLAIMS 3,634

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	489,141.23	2,151.74
MED/SURG SUPPLY	2,608,993.33	1,032,223.38
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	798,115.25	46,181.60
CT SCAN	3,643,062.40	470,545.12
PHYSICAL THERAPY	91,523.26	139,123.31
EKG/ECG	575,517.93	9,526.57
IV THERAPY	577,521.80	0.00
OPERATING ROOM	8,480,750.51	3,834,024.65
LABOR/DELIVERY ROOM	175,872.48	0.00
RESPIRATORY SERVICES	151,497.60	2,556.07
ANESTHESIA	11,158.01	0.00
GI SERVICES	433,157.94	57,136.64
EMERGENCY ROOM	2,642,771.32	2,896.85
RECOVERY ROOM	1,475,990.01	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	626,337.87	379,940.86
OCCUPATIONAL THERAPY	37,172.08	237,185.79
SPEECH PATHOLOGY	2,743.56	8,835.70
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	394,189.78	7,109.04
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	474,678.08	142,624.28
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	38,264.48	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	250,833.15	143,711.84
AUDIOLOGY	0.00	0.00
CARDIOLOGY	237,524.90	144,556.62
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,661.54	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	594,581.98	117,388.84

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	129,963.87	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	170.12
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,963,958.47	121,070.88
MRI SERVICES	330,041.22	24,713.80
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	631,545.31	337,478.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	76,982.40
IMPL DEV CHARGE PATIENTS	117,023.25	168,702.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	27,990,592.61	7,506,836.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,990,592.61	7,506,836.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	841,533.42	ADJUSTMENTS	0.00
COVERED CHARGES	384,219.22	CONTRACTUAL ALLOW	363,230.95
NON-COVERD CHARGES	457,314.20	TOTAL MEDICAID LIAB	20,988.27
		LESS: COB	20,988.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,420.54	142.62
MED/SURG SUPPLY	59,691.20	28,531.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,447.66	1,908.38
CT SCAN	8,243.90	46,180.65
PHYSICAL THERAPY	1,012.59	3,838.06
EKG/ECG	4,191.69	0.00
IV THERAPY	3,972.45	0.00
OPERATING ROOM	100,854.28	281,972.61
LABOR/DELIVERY ROOM	10,921.98	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	24,376.05
EMERGENCY ROOM	45,804.05	0.00
RECOVERY ROOM	35,786.11	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,012.59	8,824.86
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,444.99	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,536.39	10,517.04
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,175.32	6,736.44

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,650.91	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,866.56	3,129.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,186.01	33,709.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	7,447.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	384,219.22	457,314.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	384,219.22	457,314.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	926,867.04	ADJUSTMENTS	201.39
COVERED CHARGES	803,541.70	CONTRACTUAL ALLOW	788,303.19
NON-COVERD CHARGES	123,325.34	TOTAL MEDICAID LIAB	15,238.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,238.51

TOTAL NUMBER OF CLAIMS 227

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,313.79	0.00	OTHER LAB	3,868.89	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,375.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	236,687.61	92,068.23	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,758.55	6,218.09
EKG/ECG	19,688.25	0.00	MRI SERVICES	0.00	7,063.87
IV THERAPY	27,151.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	324,034.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,492.20	10,428.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	16,607.82	7,546.35	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,833.38	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,729.68	0.00			

TOTAL ANCILLARY	803,541.70	123,325.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	803,541.70	123,325.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,432.06	ADJUSTMENTS	0.00
COVERED CHARGES	12,918.15	CONTRACTUAL ALLOW	12,649.63
NON-COVERD CHARGES	1,513.91	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	653.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,943.28	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	342.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,764.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	5.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,121.00	1,508.88	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,918.15	1,513.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,918.15	1,513.91

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	320,969.36	ADJUSTMENTS	0.00
COVERED CHARGES	249,551.41	CONTRACTUAL ALLOW	236,054.91
NON-COVERD CHARGES	71,417.95	TOTAL MEDICAID LIAB	13,496.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	13,496.50

TOTAL NUMBER OF CLAIMS 2

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,162.61	142.02
MED/SURG SUPPLY	7,514.75	51,294.50
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	117,509.94	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,974.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	103,636.39	12,991.42
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	462.43	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,088.04	6,990.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	6,202.75	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	249,551.41	71,417.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	249,551.41	71,417.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,277,228.52	ADJUSTMENTS	4,635.21
COVERED CHARGES	2,270,754.79	CONTRACTUAL ALLOW	1,712,527.87
NON-COVERD CHARGES	6,473.73	TOTAL MEDICAID LIAB	558,226.92
		LESS: COB	13,714.72
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	544,512.20

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	886	0	814,900.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	886	0	814,900.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	90	0	131,400.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	90	0	131,400.00	0.00
TOTAL ACCOMODATIONS	976	0	946,300.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,320.05	0.00
MED/SURG SUPPLY	62,268.12	25.73
LABORATORY-GENERAL	204,829.77	0.00
RADIOLOGY-DIAGNOSTIC	26,709.66	0.00
CT SCAN	150,822.19	0.00
PHYSICAL THERAPY	245,891.39	0.00
EKG/ECG	21,272.64	0.00
IV THERAPY	37,665.76	0.00
OPERATING ROOM	40,712.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	88,040.58	0.00
ANESTHESIA	28,952.00	0.00
GI SERVICES	1,624.24	0.00
EMERGENCY ROOM	93,531.39	0.00
RECOVERY ROOM	6,111.00	0.00
LABORATORY PATHOLOGIC	1,781.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	140.08	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,872.84	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,474.00	6,448.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,912.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,377.13	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,552.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,600.33	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	92,206.67	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	14,787.26	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,324,454.79	6,473.73
TOTAL ACCOMODATIONS	946,300.00	0.00
TOTAL CHARGES	2,270,754.79	6,473.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,215.78	ADJUSTMENTS	0.00
COVERED CHARGES	34,215.78	CONTRACTUAL ALLOW	27,023.28
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,192.50
		LESS: COB	7,192.50
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	19	0	18,050.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	18,050.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	19	0	18,050.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,814.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,990.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,165.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	351.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	459.38	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,178.32	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,165.78	0.00
TOTAL ACCOMODATIONS	18,050.00	0.00
TOTAL CHARGES	34,215.78	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,046,623.45	ADJUSTMENTS	68,945.01
COVERED CHARGES	2,917,695.06	CONTRACTUAL ALLOW	2,342,839.17
NON-COVERD CHARGES	128,928.39	TOTAL MEDICAID LIAB	574,855.89
		LESS: COB	3,028.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	571,827.29
		ALL OTHER	512,425.06
		FEE SCHEDULE-LAB	57,218.66
		INJECTABLE DRUGS	2,183.57

TOTAL NUMBER OF CLAIMS 1,477

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,901.99	685.86
MED/SURG SUPPLY	74,938.81	25.73
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	154,189.82	2,909.75
CT SCAN	589,850.93	13,057.00
PHYSICAL THERAPY	130,045.27	5,993.20
EKG/ECG	46,382.32	2,490.80
IV THERAPY	235,252.82	3,309.18
OPERATING ROOM	78,392.00	11,013.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,970.28	2,989.00
ANESTHESIA	95,321.00	312.00
GI SERVICES	63,628.62	0.00
EMERGENCY ROOM	612,123.08	224.00
RECOVERY ROOM	10,185.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	289.67
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	61,894.00	91.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,326.00	896.10
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	61,236.95	9,056.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,575.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,915.06	5,231.72

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	89,530.82	678.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	383,473.49	55,310.75
MRI SERVICES	97,609.09	2,365.01
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,402.59	12,000.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	25,549.67	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,917,695.06	128,928.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,917,695.06	128,928.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	71,239.47	ADJUSTMENTS	0.00
COVERED CHARGES	49,940.44	CONTRACTUAL ALLOW	40,319.94
NON-COVERD CHARGES	21,299.03	TOTAL MEDICAID LIAB	9,620.50
		LESS: COB	9,620.50
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	952.68	209.27
MED/SURG SUPPLY	2,062.19	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,569.16	711.88
CT SCAN	2,240.00	12,847.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	702.32	0.00
IV THERAPY	6,680.46	1,641.46
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,919.00	887.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,844.08	224.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,634.05	234.19
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	653.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,749.93	1,877.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	586.57	2,013.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	49,940.44	21,299.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,940.44	21,299.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	227,295.37	ADJUSTMENTS	156.64
COVERED CHARGES	221,448.08	CONTRACTUAL ALLOW	211,894.06
NON-COVERD CHARGES	5,847.29	TOTAL MEDICAID LIAB	9,554.02
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,554.02

TOTAL NUMBER OF CLAIMS 122

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,547.64	66.46	OTHER LAB	1,238.00	0.00
MED/SURG SUPPLY	882.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,290.89	143.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,752.98	983.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,414.33	3,778.00
EKG/ECG	1,755.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,965.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,750.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,943.88	876.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	906.54	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	221,448.08	5,847.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	221,448.08	5,847.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,349.12	ADJUSTMENTS	0.00
COVERED CHARGES	7,163.33	CONTRACTUAL ALLOW	7,006.69
NON-COVERD CHARGES	185.79	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,050.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	652.00	146.00
EKG/ECG	351.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	640.66	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,135.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81.13	39.79
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,163.33	185.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,163.33	185.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,718.66	ADJUSTMENTS	0.00
COVERED CHARGES	32,497.81	CONTRACTUAL ALLOW	27,004.61
NON-COVERD CHARGES	2,220.85	TOTAL MEDICAID LIAB	5,493.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,493.20

TOTAL NUMBER OF CLAIMS 1

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,448.87	0.00
MED/SURG SUPPLY	4,551.89	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	155.16	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,522.00
EKG/ECG	0.00	0.00
IV THERAPY	4,235.00	0.00
OPERATING ROOM	4,916.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,363.00	0.00
ANESTHESIA	3,215.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	679.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	312.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	970.00	292.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	116.35	406.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	10,535.54	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	32,497.81	2,220.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,497.81	2,220.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,937,379.33	ADJUSTMENTS	14,065.09
COVERED CHARGES	1,896,516.08	CONTRACTUAL ALLOW	1,367,279.75
NON-COVERD CHARGES	40,863.25	TOTAL MEDICAID LIAB	529,236.33
		LESS: COB	8,926.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	520,309.45

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	476	0	596,727.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	476	0	596,727.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	62	0	88,215.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	62	0	88,215.00	0.00
TOTAL ACCOMODATIONS	538	0	684,942.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231,087.25	21,494.00
MED/SURG SUPPLY	126,525.08	0.00
LABORATORY-GENERAL	255,504.00	0.00
RADIOLOGY-DIAGNOSTIC	25,477.25	0.00
CT SCAN	71,881.00	0.00
PHYSICAL THERAPY	6,032.25	0.00
EKG/ECG	11,733.00	0.00
IV THERAPY	740.00	0.00
OPERATING ROOM	34,571.25	8,836.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	140,046.00	0.00
ANESTHESIA	7,839.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	193,536.75	0.00
RECOVERY ROOM	12,223.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	208.50	0.00
SPEECH PATHOLOGY	813.50	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 SERVICE	3,668.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,274.75	2,918.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,091.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	7,614.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	786.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,860.75	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	51,673.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,211,574.08	40,863.25
TOTAL ACCOMODATIONS	684,942.00	0.00
TOTAL CHARGES	1,896,516.08	40,863.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,862.13	ADJUSTMENTS	0.00
COVERED CHARGES	9,728.13	CONTRACTUAL ALLOW	5,199.54
NON-COVERD CHARGES	134.00	TOTAL MEDICAID LIAB	4,528.59
		LESS: COB	4,528.59
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	3,300.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	3,300.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	3,300.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,035.00	134.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	217.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,165.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,989.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,428.13	134.00
TOTAL ACCOMODATIONS	3,300.00	0.00
TOTAL CHARGES	9,728.13	134.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,328,996.22	ADJUSTMENTS	145,681.07
COVERED CHARGES	3,107,453.97	CONTRACTUAL ALLOW	2,508,537.63
NON-COVERD CHARGES	221,542.25	TOTAL MEDICAID LIAB	598,916.34
		LESS: COB	204.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	598,712.26
		ALL OTHER	514,606.86
		FEE SCHEDULE-LAB	76,173.70
		INJECTABLE DRUGS	7,931.70

TOTAL NUMBER OF CLAIMS 1,479

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,423.25	12,881.25
MED/SURG SUPPLY	85,638.47	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	107,740.50	4,113.00
CT SCAN	290,259.75	59,303.00
PHYSICAL THERAPY	19,436.75	4,885.25
EKG/ECG	23,823.50	1,161.75
IV THERAPY	158,599.50	915.00
OPERATING ROOM	94,533.50	20,551.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,406.00	8,862.00
ANESTHESIA	12,628.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	960,820.75	1,838.75
RECOVERY ROOM	19,207.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	896.00	0.00
SPEECH PATHOLOGY	0.00	821.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	18,204.50	5,252.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	45,939.25	2,261.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	211.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,688.00	12,102.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,222.25	3,074.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,645.75	1,000.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	59,981.50	7,818.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	52,183.25	305.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	778,699.50	44,886.00
MRI SERVICES	46,924.50	6,772.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	236,341.00	20,713.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	2,025.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,107,453.97	221,542.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,107,453.97	221,542.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,316.78	ADJUSTMENTS	0.00
COVERED CHARGES	6,099.53	CONTRACTUAL ALLOW	5,156.20
NON-COVERD CHARGES	217.25	TOTAL MEDICAID LIAB	943.33
		LESS: COB	943.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,343.00	93.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	231.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,250.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	123.50			

TOTAL ANCILLARY	6,099.53	217.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,099.53	217.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	123,198.56	ADJUSTMENTS	78.32
COVERED CHARGES	118,556.31	CONTRACTUAL ALLOW	112,134.07
NON-COVERD CHARGES	4,642.25	TOTAL MEDICAID LIAB	6,422.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,422.24

TOTAL NUMBER OF CLAIMS 82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,239.00	158.50
MED/SURG SUPPLY	1,454.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,898.25	0.00
CT SCAN	9,288.50	1,069.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	909.00	345.00
IV THERAPY	1,677.50	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	85,088.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	77.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,790.25	2,057.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	211.00	935.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	118,556.31	4,642.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,556.31	4,642.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,956.57	ADJUSTMENTS	0.00
COVERED CHARGES	5,880.32	CONTRACTUAL ALLOW	5,567.04
NON-COVERD CHARGES	76.25	TOTAL MEDICAID LIAB	313.28
		LESS: COB	313.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.00	35.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	138.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,117.50	31.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	305.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,124.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	10.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,880.32	76.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,880.32	76.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,206.80	ADJUSTMENTS	4,160.97
COVERED CHARGES	68,106.85	CONTRACTUAL ALLOW	38,180.87
NON-COVERD CHARGES	99.95	TOTAL MEDICAID LIAB	29,925.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	29,925.98

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	18	0	17,100.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	18	0	17,100.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	18	0	17,100.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,870.00	0.00
MED/SURG SUPPLY	5,570.41	0.00
LABORATORY-GENERAL	3,292.20	0.00
RADIOLOGY-DIAGNOSTIC	977.10	0.00
CT SCAN	13,572.00	0.00
PHYSICAL THERAPY	1,330.56	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,873.18	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,455.40	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	50.95
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	49.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,066.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	51,006.85	99.95
TOTAL ACCOMODATIONS	17,100.00	0.00
TOTAL CHARGES	68,106.85	99.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	356,280.58	ADJUSTMENTS	26,574.47
COVERED CHARGES	309,977.65	CONTRACTUAL ALLOW	167,982.26
NON-COVERD CHARGES	46,302.93	TOTAL MEDICAID LIAB	141,995.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	141,995.39
		ALL OTHER	134,293.28
		FEE SCHEDULE-LAB	7,094.80
		INJECTABLE DRUGS	607.31

TOTAL NUMBER OF CLAIMS 286

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,834.00	5,875.00
MED/SURG SUPPLY	7,935.31	2,642.04
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,619.20	447.36
CT SCAN	74,332.70	18,734.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,708.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	118,354.05	11,323.07
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,021.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,462.08	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/OBSERV. RM	21,470.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,372.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,427.21	3,666.16
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,440.64	3,615.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	309,977.65	46,302.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	309,977.65	46,302.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,781.86	ADJUSTMENTS	0.00
COVERED CHARGES	9,889.56	CONTRACTUAL ALLOW	4,818.18
NON-COVERD CHARGES	1,892.30	TOTAL MEDICAID LIAB	5,071.38
		LESS: COB	5,071.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	42.00
MED/SURG SUPPLY	126.74	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	8,338.20	1,769.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	716.70	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	707.92	60.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	21.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,889.56	1,892.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,889.56	1,892.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,991.00	ADJUSTMENTS	420.00
COVERED CHARGES	59,973.07	CONTRACTUAL ALLOW	55,633.07
NON-COVERD CHARGES	8,017.93	TOTAL MEDICAID LIAB	4,340.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,340.00

TOTAL NUMBER OF CLAIMS 62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387.00	1,733.00
MED/SURG SUPPLY	1,242.24	162.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,385.68	226.56
CT SCAN	15,762.50	3,981.90
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	392.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,279.63	1,603.67
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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,604.26	208.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	919.36	102.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	59,973.07	8,017.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,973.07	8,017.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	392.48	ADJUSTMENTS	0.00
COVERED CHARGES	392.48	CONTRACTUAL ALLOW	322.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	383.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	392.48	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	392.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,531.96	ADJUSTMENTS	4,795.19
COVERED CHARGES	37,220.53	CONTRACTUAL ALLOW	22,834.96
NON-COVERD CHARGES	4,311.43	TOTAL MEDICAID LIAB	14,385.57
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	14,385.57

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,324.00	1,068.00
MED/SURG SUPPLY	1,897.63	230.79
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	724.32	0.00
CT SCAN	5,751.20	2,212.60
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	130.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,727.70	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	21,040.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,214.28	328.04
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	410.00	472.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,220.53	4,311.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,220.53	4,311.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	462,376.12	ADJUSTMENTS	61,945.32
COVERED CHARGES	462,093.90	CONTRACTUAL ALLOW	249,518.10
NON-COVERD CHARGES	282.22	TOTAL MEDICAID LIAB	212,575.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	212,575.80

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	41	0	107,095.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	41	0	107,095.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	13,100.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	13,100.00	0.00
TOTAL ACCOMODATIONS	45	0	120,195.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,646.81	0.00	OTHER LAB	6,714.42	0.00
MED/SURG SUPPLY	8,386.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,025.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,070.29	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,264.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,518.34	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,250.50	0.00	MRI SERVICES	6,535.67	0.00
IV THERAPY	20,069.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,065.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,469.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,920.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,258.97	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,099.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,520.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	495.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,632.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,011.30	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	282.22			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,506.00	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/OBSERV. RM	25,334.40	0.00			

TOTAL ANCILLARY	341,898.90	282.22
TOTAL ACCOMODATIONS	120,195.00	0.00
TOTAL CHARGES	462,093.90	282.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,613.74	ADJUSTMENTS	0.00
COVERED CHARGES	50,613.74	CONTRACTUAL ALLOW	38,389.63
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	12,224.11
		LESS: COB	12,224.11
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	2,520.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	2,520.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	2,520.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,680.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,198.01	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,004.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,355.04	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,290.00	0.00			

TOTAL ANCILLARY	48,093.74	0.00
TOTAL ACCOMODATIONS	2,520.00	0.00
TOTAL CHARGES	50,613.74	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,482,803.84	ADJUSTMENTS	96,679.92
COVERED CHARGES	3,166,438.51	CONTRACTUAL ALLOW	2,474,501.59
NON-COVERD CHARGES	316,365.33	TOTAL MEDICAID LIAB	691,936.92
		LESS: COB	883.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	691,053.35
		ALL OTHER	637,767.95
		FEE SCHEDULE-LAB	41,141.16
		INJECTABLE DRUGS	12,144.24

TOTAL NUMBER OF CLAIMS 1,122

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,104.03	822.50
MED/SURG SUPPLY	48,849.84	23.05
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	226,334.66	26,086.72
CT SCAN	722,333.29	30,651.02
PHYSICAL THERAPY	92,342.85	2,634.00
EKG/ECG	31,836.70	0.00
IV THERAPY	141,228.94	4,614.59
OPERATING ROOM	86,734.35	11,384.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,686.58	7,814.03
ANESTHESIA	57,069.94	9,720.81
GI SERVICES	33,083.44	7,215.78
EMERGENCY ROOM	783,655.24	2,622.00
RECOVERY ROOM	44,528.24	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	28,751.90	160.00
OCCUPATIONAL THERAPY	7,820.08	697.50
SPEECH PATHOLOGY	331.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	644.54
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	69,373.74	6,488.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,662.18	704.34
ONCOLOGY	144.00	0.00
NUCLEAR MEDICINE	9,222.00	5,740.02
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,037.18	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	51,562.74	44,155.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	38,823.36	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	330.33
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	287,266.88	12,081.61
MRI SERVICES	77,119.24	0.00
PROFESSIONAL FEES	0.00	63.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	229,698.88	114,989.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	600.00	12,726.89
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	6,237.23	13,995.00

TOTAL ANCILLARY	3,166,438.51	316,365.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,166,438.51	316,365.33

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2222211000337	07/17/22 - 07/17/22	08/08/22	0.00	1,500.00	0.00	0.00	0.00
614	2222225000584	08/05/22 - 08/05/22	08/22/22	4,024.02	0.00	0.00	0.00	1,077.23
614	2022284053266	10/06/22 - 10/06/22	10/17/22	2,213.21	0.00	0.00	0.00	524.31
763	2223182000490	06/03/23 - 06/09/23	07/10/23	0.00	12,495.00	0.00	0.00	0.00
TOTAL				6,237.23	13,995.00	0.00	0.00	1,601.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,839.75	ADJUSTMENTS	0.00
COVERED CHARGES	31,962.03	CONTRACTUAL ALLOW	24,819.06
NON-COVERD CHARGES	12,877.72	TOTAL MEDICAID LIAB	7,142.97
		LESS: COB	7,142.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490.29	85.25
MED/SURG SUPPLY	7,998.08	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,471.27	0.00
CT SCAN	0.00	5,502.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,810.22	0.00
OPERATING ROOM	0.00	6,495.43
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	4,510.05	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,806.00	0.00
RECOVERY ROOM	1,854.08	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,282.71	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,434.96	49.16
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,304.37	745.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	31,962.03	12,877.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,962.03	12,877.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	302,276.60	ADJUSTMENTS	120.00
COVERED CHARGES	297,095.65	CONTRACTUAL ALLOW	288,995.65
NON-COVERD CHARGES	5,180.95	TOTAL MEDICAID LIAB	8,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,100.00

TOTAL NUMBER OF CLAIMS 135

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	587.00	3.00
MED/SURG SUPPLY	998.20	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,930.56	0.00
CT SCAN	33,003.89	3,442.74
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,625.00	0.00
IV THERAPY	9,636.27	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	191.97	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	191,062.85	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	929.96	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,122.12	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,545.30	369.21
MRI SERVICES	5,548.13	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,914.40	1,366.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	297,095.65	5,180.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	297,095.65	5,180.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,545.15	ADJUSTMENTS	0.00
COVERED CHARGES	5,305.79	CONTRACTUAL ALLOW	5,125.79
NON-COVERD CHARGES	239.36	TOTAL MEDICAID LIAB	180.00
		LESS: COB	180.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	224.00
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	630.12	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,176.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	262.82	15.36
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	236.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,305.79	239.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,305.79	239.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,877.43	ADJUSTMENTS	0.00
COVERED CHARGES	78,499.56	CONTRACTUAL ALLOW	69,023.16
NON-COVERD CHARGES	1,377.87	TOTAL MEDICAID LIAB	9,476.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,476.40

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,346.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,551.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	350.00	FEE SCHEDULE LAB	37.44	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,287.64	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,866.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,475.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	485.00	712.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,600.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,520.00	315.00			

TOTAL ANCILLARY	78,499.56	1,377.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,499.56	1,377.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	249,940.84	ADJUSTMENTS	13,730.20
COVERED CHARGES	248,703.84	CONTRACTUAL ALLOW	88,853.50
NON-COVERD CHARGES	1,237.00	TOTAL MEDICAID LIAB	159,850.34
		LESS: COB	3,945.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	155,904.60

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	70	0	50,055.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	70	0	50,055.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	70	0	50,055.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,555.00	0.00	OTHER LAB	4,121.00	0.00
MED/SURG SUPPLY	8,688.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,852.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,756.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,748.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,065.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,124.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,397.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,547.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,060.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,971.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,458.00	0.00	NO CC/INVALID REV CODE	7,140.00	89.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,941.00	1,148.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,327.00	0.00			

TOTAL ANCILLARY	198,648.84	1,237.00
TOTAL ACCOMODATIONS	50,055.00	0.00
TOTAL CHARGES	248,703.84	1,237.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022293097527	10/04/22 - 10/05/22	10/24/22	0.00	44.00	0.00	0.00	0.00
614	2222333007168	10/19/22 - 10/21/22	12/05/22	7,140.00	0.00	0.00	0.00	0.00
780	2324116000482	06/21/23 - 06/26/23	04/29/24	0.00	45.00	0.00	3,774.82	0.00
TOTAL				7,140.00	89.00	0.00	3,774.82	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,596,266.00	ADJUSTMENTS	125,903.05
COVERED CHARGES	1,520,165.00	CONTRACTUAL ALLOW	959,054.93
NON-COVERD CHARGES	76,101.00	TOTAL MEDICAID LIAB	561,110.07
		LESS: COB	129.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	560,980.33
		ALL OTHER	525,270.30
		FEE SCHEDULE-LAB	30,466.56
		INJECTABLE DRUGS	5,243.47

TOTAL NUMBER OF CLAIMS 1,014

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,809.00	4,238.00
MED/SURG SUPPLY	14,842.00	922.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,247.00	1,826.00
CT SCAN	289,276.00	12,971.00
PHYSICAL THERAPY	92,741.00	640.00
EKG/ECG	31,208.00	6,392.00
IV THERAPY	121,977.00	15,085.00
OPERATING ROOM	34,096.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,519.00	4,046.00
ANESTHESIA	3,154.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	373,709.00	4,349.00
RECOVERY ROOM	13,780.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,304.00	111.00
SPEECH PATHOLOGY	5,530.00	1,424.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	146.00	256.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	35,121.00	813.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,750.00	163.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,673.00	365.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,560.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	37,650.00	1,182.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,108.00	825.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	530.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	215,331.00	4,545.00
MRI SERVICES	21,382.00	738.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	65,905.00	14,680.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	7,347.00	0.00

TOTAL ANCILLARY	1,520,165.00	76,101.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,520,165.00	76,101.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022269030133	09/15/22 - 09/15/22	10/03/22	2,142.00	0.00	0.00	0.00	922.16
614	2022269030136	09/14/22 - 09/14/22	10/03/22	3,063.00	0.00	0.00	0.00	1,318.66
614	2022356062833	12/15/22 - 12/15/22	12/26/22	2,142.00	0.00	0.00	0.00	922.16
TOTAL				7,347.00	0.00	0.00	0.00	3,162.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,556.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,537.00	CONTRACTUAL ALLOW	1,124.92
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	412.08
		LESS: COB	412.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	708.00	19.00
EKG/ECG	376.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	383.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,537.00	19.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,537.00	19.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,119.00	ADJUSTMENTS	156.64
COVERED CHARGES	28,098.00	CONTRACTUAL ALLOW	25,200.16
NON-COVERD CHARGES	21.00	TOTAL MEDICAID LIAB	2,897.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,897.84

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93.00	6.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	96.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,013.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,801.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	251.00	0.00	FEE SCHEDULE LAB	1,071.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,275.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	216.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,306.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,604.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	372.00	15.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,098.00	21.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,098.00	21.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,299,144.34	ADJUSTMENTS	14,245.11
COVERED CHARGES	3,287,260.64	CONTRACTUAL ALLOW	2,335,944.60
NON-COVERD CHARGES	11,883.70	TOTAL MEDICAID LIAB	951,316.04
		LESS: COB	13,517.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	937,798.16

TOTAL NUMBER OF ADMISSIONS 154

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	919	0	1,373,766.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	919	0	1,373,766.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	158	0	174,116.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	158	0	174,116.00	0.00
TOTAL ACCOMODATIONS	1,077	0	1,547,882.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	292,218.93	0.00	OTHER LAB	15,069.39	0.00
MED/SURG SUPPLY	68,186.39	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	466,012.67	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,491.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	270,550.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,775.58	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,339.24	0.00	MRI SERVICES	4,337.98	0.00
IV THERAPY	84,733.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,306.23	7,366.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	202,330.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,644.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,630.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,356.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,946.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,809.33	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	214.50	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	5,183.34	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,596.50	4,333.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,911.16	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,703.83	0.00			

TOTAL ANCILLARY	1,739,378.64	11,883.70
TOTAL ACCOMODATIONS	1,547,882.00	0.00
TOTAL CHARGES	3,287,260.64	11,883.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,017,735.05	ADJUSTMENTS	69,154.14
COVERED CHARGES	3,706,713.21	CONTRACTUAL ALLOW	3,219,073.23
NON-COVERD CHARGES	311,021.84	TOTAL MEDICAID LIAB	487,639.98
		LESS: COB	2,521.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	485,118.60
		ALL OTHER	418,670.68
		FEE SCHEDULE-LAB	65,182.74
		INJECTABLE DRUGS	1,265.18

TOTAL NUMBER OF CLAIMS 1,268

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,415.29	45,266.75
MED/SURG SUPPLY	118,594.65	15,527.39
LABORATORY-GENERAL	0.00	398.00
RADIOLOGY-DIAGNOSTIC	152,874.64	21,377.65
CT SCAN	678,136.62	24,129.68
PHYSICAL THERAPY	0.00	305.00
EKG/ECG	45,584.28	1,632.56
IV THERAPY	220,648.76	7,756.80
OPERATING ROOM	88,593.25	19,957.13
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,292.99	968.93
ANESTHESIA	46,744.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	886,584.40	16,064.48
RECOVERY ROOM	54,668.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	91.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,072.10	3,248.90
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	117,776.52	168.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,942.90	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,047.00	50,445.32
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,265.33	3,690.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,270.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	78,416.41	4,400.76

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,270.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	923,140.12	52,778.62
MRI SERVICES	118,534.40	8,205.60
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,841.05	20,422.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	4,587.02
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,706,713.21	301,421.84
TOTAL ACCOMODATIONS	0.00	9,600.00
TOTAL CHARGES	3,706,713.21	311,021.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,071.87	ADJUSTMENTS	0.00
COVERED CHARGES	30,190.18	CONTRACTUAL ALLOW	25,940.63
NON-COVERD CHARGES	12,881.69	TOTAL MEDICAID LIAB	4,249.55
		LESS: COB	4,249.55
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,577.38	521.00
MED/SURG SUPPLY	5,801.06	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	871.20	590.20
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	299.00	0.00
IV THERAPY	1,511.00	0.00
OPERATING ROOM	0.00	8,915.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	239.96	0.00
ANESTHESIA	2,744.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,505.10	0.00
RECOVERY ROOM	3,432.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,006.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,006.64	994.47
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	202.84	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	854.62
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	30,190.18	12,881.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,190.18	12,881.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	424,151.83	ADJUSTMENTS	939.84
COVERED CHARGES	409,266.20	CONTRACTUAL ALLOW	397,126.60
NON-COVERD CHARGES	14,885.63	TOTAL MEDICAID LIAB	12,139.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,139.60

TOTAL NUMBER OF CLAIMS 155

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,794.85	2,071.15
MED/SURG SUPPLY	5,399.64	46.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,040.26	3,006.90
CT SCAN	71,323.02	3,551.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,408.48	0.00
IV THERAPY	25,926.30	1,127.30
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,443.88	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	193,606.64	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,574.30	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/OBSERV. RM	2,079.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,692.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	77,743.73	4,641.78
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	233.50	441.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	409,266.20	14,885.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	409,266.20	14,885.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,921.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,921.00	CONTRACTUAL ALLOW	2,764.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,076.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,806.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,921.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,921.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,186,521.80	ADJUSTMENTS	10,776,119.41
COVERED CHARGES	147,466,496.00	CONTRACTUAL ALLOW	117,503,025.85
NON-COVERD CHARGES	1,720,025.80	TOTAL MEDICAID LIAB	29,963,470.15
		LESS: COB	143,583.15
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	848,000.00
		REIMBURSEMENT	30,667,887.00

TOTAL NUMBER OF ADMISSIONS 1,278

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,459	0	13,489,577.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,459	0	13,489,577.00	0.00
SPECIAL CARE SERVICES				
CCU	26	0	211,666.00	0.00
ICU	3,908	0	26,294,499.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,934	0	26,506,165.00	0.00
TOTAL ACCOMODATIONS	11,393	0	39,995,742.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,472,465.85	0.00
MED/SURG SUPPLY	4,731,787.69	357,335.88
LABORATORY-GENERAL	21,418,530.36	0.00
RADIOLOGY-DIAGNOSTIC	1,440,212.00	0.00
CT SCAN	3,410,771.00	41,181.00
PHYSICAL THERAPY	753,804.00	0.00
EKG/ECG	482,277.00	0.00
IV THERAPY	299,476.00	0.00
OPERATING ROOM	18,298,053.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,773,417.00	0.00
ANESTHESIA	3,510,746.00	0.00
GI SERVICES	617,843.00	0.00
EMERGENCY ROOM	1,923,120.00	0.00
RECOVERY ROOM	905,500.00	0.00
LABORATORY PATHOLOGIC	745,370.00	3,900.00
RADIOLOGY THERAPEUTIC	340,760.00	0.00
OCCUPATIONAL THERAPY	596,335.00	0.00
SPEECH PATHOLOGY	178,414.00	0.00
RENAL DIALYSIS	946,439.00	20,086.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,492.00	0.00
PSYCHIATRIC SERVICES	364.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	562,918.00	159,441.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,946,084.80	920,390.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,950.00	58,985.52
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,013,573.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	729,383.00	0.00
ORGAN ACQUISITION	1,689,597.25	0.00
TREATMENT/OBSERV. RM	4,881,071.00	69,977.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	865,173.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,865.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,133,117.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	80,558.40
INJECTABLE DRUGS	5,188,907.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,934,642.20	0.00
GENE THERAPY DRUGS	3,341,120.00	0.00
NO CC/INVALID REV CODE	301,175.00	8,171.00

TOTAL ANCILLARY	107,470,754.00	1,720,025.80
TOTAL ACCOMODATIONS	39,995,742.00	0.00
TOTAL CHARGES	147,466,496.00	1,720,025.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022292002965	10/06/22 - 10/12/22	10/24/22	2,296.00	0.00	0.00	0.00	0.00
614	2022298088784	10/05/22 - 10/21/22	10/31/22	2,296.00	0.00	0.00	0.00	0.00
614	2322307000194	09/17/22 - 09/21/22	11/07/22	3,812.00	0.00	0.00	730.13	0.00
614	2222314007286	10/16/22 - 10/22/22	11/14/22	3,812.00	0.00	0.00	0.00	0.00
614	2022319014255	10/18/22 - 10/24/22	11/21/22	4,592.00	0.00	0.00	0.00	0.00
614	2022320002084	11/01/22 - 11/08/22	11/21/22	2,296.00	0.00	0.00	0.00	0.00
614	2022322003408	10/06/22 - 10/13/22	11/21/22	2,296.00	0.00	0.00	0.00	0.00
614	2022322003540	10/28/22 - 11/13/22	11/21/22	3,812.00	0.00	0.00	0.00	0.00
614	2022326103291	11/09/22 - 11/18/22	11/28/22	2,296.00	0.00	0.00	0.00	0.00
614	2022327098658	09/20/22 - 10/03/22	11/28/22	3,812.00	0.00	0.00	0.00	0.00
614	2022333066371	11/08/22 - 11/22/22	12/05/22	3,812.00	0.00	0.00	0.00	0.00
614	2022334084157	11/20/22 - 11/25/22	12/05/22	7,624.00	0.00	0.00	0.00	0.00
614	2222335001681	10/24/22 - 10/26/22	12/05/22	3,812.00	0.00	0.00	0.00	0.00
614	2022336086173	11/22/22 - 11/29/22	12/12/22	3,812.00	0.00	0.00	0.00	0.00
615	2022336086535	11/16/22 - 11/29/22	12/12/22	7,624.00	0.00	0.00	0.00	0.00
614	2022340070099	11/28/22 - 12/02/22	12/12/22	3,358.00	0.00	0.00	0.00	0.00
614	2022340070870	10/28/22 - 10/31/22	12/12/22	3,812.00	0.00	0.00	0.00	0.00
614	2022347065296	11/12/22 - 12/01/22	12/19/22	3,812.00	0.00	0.00	0.00	0.00
614	2022355134592	12/08/22 - 12/17/22	12/26/22	3,358.00	0.00	0.00	0.00	0.00
615	2022355134661	11/26/22 - 12/09/22	12/26/22	7,624.00	0.00	0.00	0.00	0.00
614	2022363000116	12/20/22 - 12/23/22	01/02/23	3,812.00	0.00	0.00	0.00	0.00
615	2223010001274	11/10/22 - 11/22/22	01/16/23	3,812.00	0.00	0.00	0.00	0.00
614	5223011070485	11/25/22 - 12/06/22	01/16/23	3,812.00	0.00	0.00	0.00	0.00
614	5223020000068	10/15/22 - 10/24/22	01/30/23	3,812.00	0.00	0.00	0.00	0.00
615	5923024001341	12/25/22 - 01/03/23	01/30/23	3,812.00	0.00	0.00	0.00	0.00
614	5923025001163	12/31/22 - 01/06/23	01/30/23	3,812.00	0.00	0.00	0.00	0.00
614	2023026080122	01/13/23 - 01/23/23	01/30/23	7,624.00	0.00	0.00	0.00	0.00
614	2023030038396	12/30/22 - 01/25/23	02/06/23	7,624.00	0.00	0.00	0.00	0.00
614	2023032000114	01/25/23 - 01/27/23	02/06/23	3,812.00	0.00	0.00	0.00	0.00
614	2023037053078	01/30/23 - 02/02/23	02/13/23	7,624.00	0.00	0.00	0.00	0.00
615	2023059068753	02/22/23 - 02/24/23	03/06/23	7,624.00	0.00	0.00	0.00	0.00
614	2223062012887	02/06/23 - 02/20/23	03/06/23	2,115.00	0.00	0.00	0.00	0.00
614	2223065000498	02/13/23 - 02/16/23	03/13/23	3,812.00	0.00	0.00	0.00	0.00
614	2223066006013	12/16/22 - 01/31/23	03/13/23	7,624.00	0.00	0.00	0.00	0.00
614	5223066060435	01/21/23 - 01/31/23	03/13/23	7,624.00	0.00	0.00	0.00	0.00
614	2023066074656	02/28/23 - 03/03/23	03/13/23	3,812.00	0.00	0.00	0.00	0.00
614	2023066076014	02/23/23 - 03/02/23	03/13/23	7,624.00	0.00	0.00	0.00	0.00
614	2023067093749	02/23/23 - 03/02/23	03/13/23	3,812.00	0.00	0.00	0.00	0.00
614	2323075000317	10/27/22 - 11/07/22	04/17/23	3,812.00	0.00	0.00	0.00	0.00
614	2223083005403	02/17/23 - 03/01/23	03/27/23	2,376.00	0.00	0.00	0.00	0.00
614	5923089001575	12/12/22 - 12/25/22	04/03/23	2,296.00	0.00	0.00	0.00	0.00
614	2023095000046	03/27/23 - 03/31/23	04/10/23	7,624.00	0.00	0.00	0.00	0.00

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	5923101000031	01/16/23 - 01/21/23	04/17/23	3,812.00	0.00	0.00	0.00	0.00
614	2023101076976	03/26/23 - 04/06/23	04/17/23	4,592.00	0.00	0.00	0.00	0.00
614	2023102083411	03/29/23 - 04/06/23	04/17/23	2,376.00	0.00	0.00	0.00	0.00
614	5923103001374	01/23/23 - 02/28/23	04/17/23	3,812.00	0.00	0.00	0.00	0.00
615	5923103001377	01/19/23 - 03/16/23	04/17/23	4,592.00	0.00	0.00	0.00	0.00
614	2023112026302	04/11/23 - 04/18/23	05/01/23	7,624.00	0.00	0.00	0.00	0.00
614	2023114041202	03/23/23 - 03/31/23	05/01/23	2,296.00	0.00	0.00	0.00	0.00
614	5923114001253	03/15/23 - 03/22/23	05/01/23	4,592.00	0.00	0.00	0.00	0.00
615	2023116000142	04/15/23 - 04/18/23	05/01/23	7,624.00	0.00	0.00	0.00	0.00
614	2023116100375	03/11/23 - 03/17/23	05/01/23	3,812.00	0.00	0.00	0.00	0.00
614	2023117090202	02/16/23 - 02/25/23	05/01/23	3,812.00	0.00	0.00	0.00	0.00
614	2023117090741	04/20/23 - 04/24/23	05/01/23	7,624.00	0.00	0.00	0.00	0.00
614	2223118008862	10/27/22 - 11/21/22	05/01/23	3,812.00	0.00	0.00	0.00	0.00
614	5923121000905	03/12/23 - 03/28/23	05/08/23	3,812.00	0.00	0.00	0.00	0.00
614	2023121057908	02/01/23 - 04/28/23	05/08/23	7,624.00	0.00	0.00	0.00	0.00
614	2023125093553	05/01/23 - 05/02/23	05/15/23	3,812.00	0.00	0.00	0.00	0.00
614	2023125093727	04/26/23 - 04/30/23	05/15/23	3,812.00	0.00	0.00	0.00	0.00
614	2023128039045	04/25/23 - 05/03/23	05/15/23	4,592.00	0.00	0.00	0.00	0.00
614	5223137092884	12/05/22 - 12/23/22	05/22/23	3,812.00	0.00	0.00	0.00	0.00
874	5923158060485	12/18/22 - 01/01/23	06/12/23	0.00	1,045.00	0.00	0.00	0.00
615	2223170004035	05/21/23 - 05/23/23	06/26/23	2,296.00	0.00	0.00	0.00	0.00
615	2023185040859	06/04/23 - 06/30/23	07/10/23	7,624.00	0.00	0.00	0.00	0.00
615	2223198002943	06/28/23 - 06/30/23	07/24/23	6,108.00	0.00	0.00	0.00	0.00
614	2223200006409	04/05/23 - 04/09/23	07/24/23	3,812.00	0.00	0.00	0.00	0.00
615	2023216094001	11/06/22 - 11/23/22	08/14/23	3,812.00	0.00	0.00	0.00	0.00
618	2223275003369	06/02/23 - 08/04/23	10/09/23	0.00	6,081.00	0.00	0.00	0.00
874	5223295000407	03/06/23 - 04/12/23	10/30/23	0.00	1,045.00	0.00	0.00	0.00
TOTAL				301,175.00	8,171.00	0.00	730.13	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,822,269.72	ADJUSTMENTS	0.00
COVERED CHARGES	1,805,171.20	CONTRACTUAL ALLOW	1,487,666.31
NON-COVERD CHARGES	17,098.52	TOTAL MEDICAID LIAB	317,504.89
		LESS: COB	317,504.89
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	90	0	162,630.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	90	0	162,630.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	64	0	398,924.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	64	0	398,924.00	0.00
TOTAL ACCOMODATIONS	154	0	561,554.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,973.67	0.00	OTHER LAB	13,665.00	0.00
MED/SURG SUPPLY	37,159.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	270,205.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,793.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,493.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,184.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,852.00	0.00	MRI SERVICES	34,308.00	0.00
IV THERAPY	2,270.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	142,935.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128,964.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,400.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,756.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,345.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,436.00	0.00	INJECTABLE DRUGS	56,128.75	0.00
RADIOLOGY THERAPEUTIC	1,072.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,435.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,994.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,504.85	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,458.00	9,969.00	NO CC/INVALID REV CODE	7,624.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,601.00	7,129.52			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	70,133.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,253.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,364.00	0.00			

TOTAL ANCILLARY	1,243,617.20	17,098.52
TOTAL ACCOMODATIONS	561,554.00	0.00
TOTAL CHARGES	1,805,171.20	17,098.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023061109562	02/08/23 - 02/14/23	03/06/23	3,812.00	0.00	0.00	11,855.23	0.00
615	2023222000152	02/12/23 - 03/10/23	08/14/23	3,812.00	0.00	0.00	19,563.73	0.00
TOTAL				7,624.00	0.00	0.00	31,418.96	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,483,162.36	ADJUSTMENTS	557,323.67
COVERED CHARGES	23,815,884.17	CONTRACTUAL ALLOW	20,046,020.34
NON-COVERD CHARGES	9,667,278.19	TOTAL MEDICAID LIAB	3,769,863.83
		LESS: COB	12,305.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,757,558.63
		ALL OTHER	3,022,835.70
		FEE SCHEDULE-LAB	613,203.63
		INJECTABLE DRUGS	121,519.30

TOTAL NUMBER OF CLAIMS 9,589

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,759.44	287,117.83
MED/SURG SUPPLY	586,529.16	41,429.50
LABORATORY-GENERAL	0.00	59.00
RADIOLOGY-DIAGNOSTIC	348,700.00	82,977.00
CT SCAN	1,484,220.00	581,314.00
PHYSICAL THERAPY	0.00	44,083.00
EKG/ECG	212,976.00	5,916.00
IV THERAPY	455,779.00	18,746.00
OPERATING ROOM	3,140,176.26	1,633,699.74
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	51,945.00	5,312.00
ANESTHESIA	1,032,633.00	0.00
GI SERVICES	201,839.00	122,751.00
EMERGENCY ROOM	2,090,628.00	12,720.00
RECOVERY ROOM	781,561.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	990,257.00	293,074.00
OCCUPATIONAL THERAPY	0.00	21,911.00
SPEECH PATHOLOGY	0.00	3,393.00
RENAL DIALYSIS	0.00	92,602.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,549.00	1,749.00
PSYCHIATRIC SERVICES	13,537.00	4,200.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	691,063.00	533,871.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	126,988.00	58,899.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	154,499.00	221,577.41
AUDIOLOGY	0.00	0.00
CARDIOLOGY	778,662.00	1,047,068.00
AMBULATORY SURGERY	903.00	8,501.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	22,584.00	6,424.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,227,350.21	344,167.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	159,693.00	558.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,352.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,960,602.73	1,719,472.48
MRI SERVICES	1,205,285.00	227,662.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	5,441.69	0.00
INJECTABLE DRUGS	412,513.84	854,018.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	133,772.84	1,321,847.81
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	266,437.00	68,806.00

TOTAL ANCILLARY	23,815,884.17	9,667,278.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,815,884.17	9,667,278.19

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022256084878	09/06/22 - 09/06/22	09/19/22	39.00	0.00	0.00	0.00	20.52
780	2022258081970	09/07/22 - 09/07/22	09/19/22	39.00	0.00	0.00	0.00	20.52
780	2022270064277	09/19/22 - 09/19/22	10/03/22	39.00	0.00	0.00	0.00	20.52
780	2022271077339	09/15/22 - 09/15/22	10/03/22	38.00	0.00	0.00	0.00	20.52
780	2022276055652	09/26/22 - 09/26/22	10/10/22	39.00	0.00	0.00	0.00	20.52
780	2022277064755	09/26/22 - 09/26/22	10/10/22	38.00	0.00	0.00	0.00	20.52
780	2022297036833	09/14/22 - 09/14/22	10/31/22	38.00	0.00	0.00	18.62	15.57
614	2022298002383	10/20/22 - 10/20/22	10/31/22	3,812.00	0.00	0.00	0.00	688.78
780	2022298084028	09/13/22 - 09/13/22	10/31/22	39.00	0.00	0.00	0.00	20.52
614	2022300077472	10/24/22 - 10/24/22	10/31/22	3,812.00	0.00	0.00	0.00	688.78
614	2022300077590	10/24/22 - 10/24/22	10/31/22	3,812.00	0.00	0.00	0.00	688.78
614	2022301093184	10/19/22 - 10/19/22	11/07/22	3,812.00	0.00	0.00	0.00	688.78
614	2022301093184	10/19/22 - 10/19/22	11/07/22	3,812.00	0.00	0.00	0.00	688.78
614	2022314099370	10/12/22 - 10/12/22	11/14/22	3,812.00	0.00	0.00	0.00	688.78
614	2022314099379	11/01/22 - 11/01/22	11/14/22	3,812.00	0.00	0.00	0.00	688.78
780	2022314099490	10/31/22 - 10/31/22	11/14/22	38.00	0.00	0.00	0.00	20.52
614	2022320068259	10/13/22 - 10/13/22	11/21/22	3,812.00	0.00	0.00	0.00	688.78
780	2022327099056	10/31/22 - 10/31/22	11/28/22	38.00	0.00	0.00	0.00	20.52
614	2022327099148	10/07/22 - 10/07/22	11/28/22	3,812.00	0.00	0.00	0.00	688.78
614	2022335112457	11/28/22 - 11/28/22	12/05/22	3,812.00	0.00	0.00	0.00	688.78
614	2022339046449	11/30/22 - 11/30/22	12/12/22	3,812.00	0.00	0.00	0.00	688.78
614	2022339046449	11/30/22 - 11/30/22	12/12/22	564.00	0.00	0.00	0.00	101.91
614	2022339046633	12/02/22 - 12/02/22	12/12/22	3,812.00	0.00	0.00	0.00	688.78
614	2022339046659	12/02/22 - 12/02/22	12/12/22	2,296.00	0.00	0.00	0.00	414.85
614	2022344013164	11/16/22 - 11/16/22	12/19/22	3,812.00	0.00	0.00	0.00	688.78
614	2022347067063	12/07/22 - 12/07/22	12/19/22	3,812.00	0.00	0.00	0.00	688.78
614	2022347067063	12/07/22 - 12/07/22	12/19/22	564.00	0.00	0.00	0.00	101.91
780	2022354030018	11/17/22 - 11/17/22	12/26/22	38.00	0.00	0.00	0.00	20.52
614	2022355024292	12/10/22 - 12/10/22	12/26/22	3,812.00	0.00	0.00	0.00	688.78
780	2022357065541	11/02/22 - 11/02/22	01/02/23	38.00	0.00	0.00	0.00	20.52
614	2022357065752	12/19/22 - 12/19/22	01/02/23	3,812.00	0.00	0.00	0.00	688.78
614	2022360013052	12/22/22 - 12/22/22	01/02/23	3,812.00	0.00	0.00	0.00	688.78
614	5922364000865	11/21/22 - 11/21/22	01/02/23	3,812.00	0.00	0.00	0.00	688.78
614	2023002019891	12/29/22 - 12/29/22	01/09/23	2,296.00	0.00	0.00	0.00	414.85
614	2023002019926	11/05/22 - 11/05/22	01/09/23	3,812.00	0.00	0.00	0.00	688.78
780	2023009044731	11/29/22 - 11/29/22	01/16/23	38.00	0.00	0.00	0.00	20.52
614	5923018000644	12/02/22 - 12/02/22	01/23/23	3,812.00	0.00	0.00	0.00	688.78
615	5923018000644	11/28/22 - 11/28/22	01/23/23	3,812.00	0.00	0.00	0.00	688.78
614	2223018007530	10/06/22 - 10/06/22	01/23/23	3,812.00	0.00	0.00	0.00	688.78
614	2223018007530	10/06/22 - 10/06/22	01/23/23	3,812.00	0.00	0.00	0.00	688.78
780	2023023043905	12/05/22 - 12/05/22	01/30/23	38.00	0.00	0.00	13.49	7.03
614	2223025007695	12/29/22 - 12/29/22	01/30/23	2,376.00	0.00	0.00	0.00	429.31

EMORY UNIV HOSPPT FINANCIALSERV
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2223026004732	12/07/22 - 12/07/22	01/30/23	2,296.00	0.00	0.00	0.00	414.85
614	2023045064033	02/10/23 - 02/10/23	02/20/23	3,812.00	0.00	0.00	0.00	688.78
614	2023048087872	01/19/23 - 01/19/23	02/27/23	3,812.00	0.00	0.00	0.00	688.78
614	2223051004555	10/18/22 - 10/18/22	02/27/23	0.00	3,812.00	0.00	0.00	0.00
614	2023052070792	01/16/23 - 01/16/23	02/27/23	0.00	3,812.00	0.00	0.00	0.00
780	2023053003854	02/17/23 - 02/17/23	02/27/23	38.00	0.00	0.00	0.00	20.52
780	5923053001323	10/19/22 - 10/19/22	02/27/23	38.00	0.00	0.00	0.00	20.52
780	2023054112860	01/09/23 - 01/09/23	02/27/23	38.00	0.00	0.00	0.00	20.52
780	2023054112886	02/13/23 - 02/13/23	02/27/23	38.00	0.00	0.00	0.00	20.52
614	2023055097699	01/25/23 - 01/25/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
614	2023058044149	01/26/23 - 01/26/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
614	2023058044149	01/26/23 - 01/26/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
780	2023058045347	12/19/22 - 12/19/22	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023058051201	02/23/23 - 02/23/23	03/06/23	38.00	0.00	0.00	0.00	20.52
614	2023058051207	02/24/23 - 02/24/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
614	5923059000782	01/12/23 - 01/12/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
780	2023059071886	02/16/23 - 02/16/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023059071897	02/23/23 - 02/23/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023061115602	02/27/23 - 02/27/23	03/06/23	38.00	0.00	0.00	0.00	20.52
614	2023061115614	01/30/23 - 01/30/23	03/06/23	3,812.00	0.00	0.00	0.00	688.78
780	2023061115689	02/27/23 - 02/27/23	03/06/23	38.00	0.00	0.00	0.00	20.52
780	2023066028816	03/03/23 - 03/03/23	03/13/23	38.00	0.00	0.00	0.00	20.52
780	2023066028861	02/20/23 - 02/20/23	03/13/23	38.00	0.00	0.00	18.89	1.63
780	2023066028890	03/02/23 - 03/02/23	03/13/23	38.00	0.00	0.00	0.00	20.52
614	5923066000640	01/19/23 - 01/19/23	03/13/23	0.00	3,812.00	0.00	0.00	0.00
614	5923066000640	01/19/23 - 01/19/23	03/13/23	0.00	3,812.00	0.00	0.00	0.00
780	2023066079634	03/02/23 - 03/02/23	03/13/23	38.00	0.00	0.00	0.00	20.52
614	2223067001061	01/21/23 - 01/21/23	03/13/23	3,812.00	0.00	0.00	0.00	688.78
780	2023068126726	03/01/23 - 03/01/23	03/13/23	38.00	0.00	0.00	0.00	20.52
780	2023072046238	03/08/23 - 03/08/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023072046400	03/08/23 - 03/08/23	03/20/23	38.00	0.00	0.00	0.00	20.52
780	2023072046549	03/09/23 - 03/09/23	03/20/23	38.00	0.00	0.00	0.00	20.52
614	2223074004377	02/20/23 - 02/20/23	03/20/23	2,376.00	0.00	0.00	0.00	429.31
614	2223074004592	02/24/23 - 02/24/23	03/20/23	2,376.00	0.00	0.00	0.00	429.31
615	2023076112115	02/14/23 - 02/14/23	03/27/23	0.00	3,812.00	0.00	0.00	0.00
780	2023080037723	03/15/23 - 03/15/23	03/27/23	38.00	0.00	0.00	0.00	20.52
615	5923080001217	02/23/23 - 02/23/23	03/27/23	0.00	3,812.00	0.00	0.00	0.00
780	2023081011035	03/16/23 - 03/16/23	03/27/23	38.00	0.00	0.00	0.00	20.52
614	2223082001950	02/02/23 - 02/02/23	03/27/23	3,812.00	0.00	0.00	0.00	688.78
780	2023082103849	03/09/23 - 03/09/23	03/27/23	38.00	0.00	0.00	0.00	20.52
780	2023082104350	03/20/23 - 03/20/23	03/27/23	38.00	0.00	0.00	0.00	20.52
614	2023082104409	02/20/23 - 02/20/23	03/27/23	0.00	3,812.00	0.00	0.00	0.00
780	2023087013499	03/09/23 - 03/09/23	04/03/23	38.00	0.00	0.00	18.89	1.63
780	2023087009269	03/24/23 - 03/24/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023087009430	03/09/23 - 03/09/23	04/03/23	38.00	0.00	0.00	0.00	20.52
780	2023087009594	03/23/23 - 03/23/23	04/03/23	38.00	0.00	0.00	0.00	20.52

EMORY UNIV HOSPPT FINANCIALSERV
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SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2023087009713	02/08/23 - 02/08/23	04/03/23	3,812.00	0.00	0.00	0.00	688.78
780	2023093049776	03/21/23 - 03/21/23	04/10/23	38.00	0.00	0.00	0.00	20.52
614	2023093050079	03/30/23 - 03/30/23	04/10/23	2,296.00	0.00	0.00	0.00	414.85
780	2023093050121	03/30/23 - 03/30/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023093050231	03/31/23 - 03/31/23	04/10/23	38.00	0.00	0.00	0.00	20.52
780	2023093050326	03/02/23 - 03/02/23	04/10/23	38.00	0.00	0.00	0.00	20.52
614	5923095000979	11/04/22 - 11/04/22	04/10/23	3,812.00	0.00	0.00	0.00	688.78
614	5923095000979	11/04/22 - 11/04/22	04/10/23	3,812.00	0.00	0.00	0.00	688.78
614	2023097031366	04/03/23 - 04/03/23	04/10/23	0.00	3,812.00	0.00	0.00	0.00
780	2023097031461	04/03/23 - 04/03/23	04/10/23	38.00	0.00	0.00	0.00	20.52
614	2023097090270	03/06/23 - 03/06/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
614	2023097090270	03/06/23 - 03/06/23	04/17/23	564.00	0.00	0.00	0.00	101.91
614	2223100006181	03/16/23 - 03/16/23	04/17/23	2,296.00	0.00	0.00	0.00	414.85
614	2023101004980	03/08/23 - 03/08/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
614	2023101006308	04/06/23 - 04/06/23	04/17/23	3,812.00	0.00	0.00	0.00	688.78
614	2023101006308	04/06/23 - 04/06/23	04/17/23	3,812.00	0.00	0.00	0.00	688.78
780	2023101006859	04/07/23 - 04/07/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023101006982	04/04/23 - 04/04/23	04/17/23	38.00	0.00	0.00	0.00	20.52
614	5923102000141	11/07/22 - 11/07/22	04/17/23	5,380.00	0.00	0.00	0.00	972.09
780	2023103085439	04/10/23 - 04/10/23	04/17/23	38.00	0.00	0.00	0.00	20.52
780	2023103085469	04/03/23 - 04/03/23	04/17/23	38.00	0.00	0.00	0.00	20.52
614	2023103085499	03/13/23 - 03/13/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
614	2023103085499	03/13/23 - 03/13/23	04/17/23	0.00	3,812.00	0.00	0.00	0.00
780	2023103085537	04/10/23 - 04/10/23	04/17/23	38.00	0.00	0.00	0.00	20.52
614	2023103084451	03/20/23 - 03/20/23	04/17/23	3,812.00	0.00	0.00	0.00	688.78
614	2023104085286	03/17/23 - 03/17/23	04/24/23	3,812.00	0.00	0.00	0.00	688.78
780	2023104085293	12/19/22 - 12/19/22	04/24/23	38.00	0.00	0.00	0.00	20.52
614	2023104085319	03/14/23 - 03/14/23	04/24/23	0.00	2,296.00	0.00	0.00	0.00
780	2023107057999	04/12/23 - 04/12/23	04/24/23	38.00	0.00	0.00	0.00	20.52
614	2023107058029	03/17/23 - 03/17/23	04/24/23	3,812.00	0.00	0.00	0.00	688.78
614	2023107058029	03/17/23 - 03/17/23	04/24/23	564.00	0.00	0.00	0.00	101.91
780	2023107058227	04/06/23 - 04/06/23	04/24/23	38.00	0.00	0.00	0.00	20.52
614	2023107058242	03/16/23 - 03/16/23	04/24/23	3,812.00	0.00	0.00	0.00	688.78
614	2223111006026	03/06/23 - 03/06/23	04/24/23	3,812.00	0.00	0.00	0.00	688.78
780	2023114043513	04/20/23 - 04/20/23	05/01/23	38.00	0.00	0.00	0.00	20.52
614	2023114043522	04/20/23 - 04/20/23	05/01/23	3,812.00	0.00	0.00	0.00	688.78
780	2023114043561	03/23/23 - 03/23/23	05/01/23	38.00	0.00	0.00	0.00	20.52
614	5923118000457	03/02/23 - 03/02/23	05/01/23	3,812.00	0.00	0.00	0.00	688.78
614	5923118000958	03/01/23 - 03/01/23	05/01/23	3,812.00	0.00	0.00	0.00	688.78
614	5923118000958	03/01/23 - 03/01/23	05/01/23	564.00	0.00	0.00	0.00	101.91
614	2023118089140	04/25/23 - 04/25/23	05/08/23	3,812.00	0.00	0.00	0.00	688.78
615	2023118089376	03/28/23 - 03/28/23	05/08/23	3,812.00	0.00	0.00	0.00	688.78
780	2023121058390	04/26/23 - 04/26/23	05/08/23	38.00	0.00	0.00	0.00	20.52
780	2023121058554	04/27/23 - 04/27/23	05/08/23	38.00	0.00	0.00	0.00	20.52
780	2023122019074	03/30/23 - 03/30/23	05/08/23	38.00	0.00	0.00	0.00	20.52
614	2023122019088	04/28/23 - 04/28/23	05/08/23	3,812.00	0.00	0.00	0.00	688.78

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2023122019088	04/28/23 - 04/28/23	05/08/23	3,812.00	0.00	0.00	0.00	688.78
780	2023123039762	04/24/23 - 04/24/23	05/08/23	38.00	0.00	0.00	0.00	20.52
780	2023123115708	04/27/23 - 04/27/23	05/08/23	38.00	0.00	0.00	0.00	20.52
614	2023123117038	04/12/23 - 04/12/23	05/08/23	0.00	3,358.00	0.00	0.00	0.00
615	2023125023646	04/03/23 - 04/03/23	05/08/23	3,812.00	0.00	0.00	0.00	688.78
780	2023128038944	05/03/23 - 05/03/23	05/15/23	38.00	0.00	0.00	0.00	20.52
614	2023128038957	05/03/23 - 05/03/23	05/15/23	3,812.00	0.00	0.00	0.00	688.78
614	2023128038957	05/03/23 - 05/03/23	05/15/23	3,812.00	0.00	0.00	0.00	688.78
780	2023128039134	04/17/23 - 04/17/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023128039140	04/05/23 - 04/05/23	05/15/23	38.00	0.00	0.00	0.00	20.52
614	2023128040591	05/04/23 - 05/04/23	05/15/23	3,812.00	0.00	0.00	0.00	688.78
780	2023129071444	04/07/23 - 04/07/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023129071474	05/04/23 - 05/04/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023129071483	05/04/23 - 05/04/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023130080780	04/26/23 - 04/26/23	05/15/23	38.00	0.00	0.00	11.09	9.43
614	5923131000138	04/12/23 - 04/12/23	05/15/23	3,812.00	0.00	0.00	0.00	688.78
780	2023131098589	05/08/23 - 05/08/23	05/15/23	38.00	0.00	0.00	0.00	20.52
780	2023131098727	05/04/23 - 05/04/23	05/15/23	38.00	0.00	0.00	0.00	20.52
615	2023135043098	04/12/23 - 04/12/23	05/22/23	0.00	3,812.00	0.00	0.00	0.00
615	2023135043098	04/12/23 - 04/12/23	05/22/23	3,812.00	0.00	0.00	0.00	688.78
780	2023135043162	05/10/23 - 05/10/23	05/22/23	38.00	0.00	0.00	0.00	20.52
780	2023135043464	05/10/23 - 05/10/23	05/22/23	38.00	0.00	0.00	0.00	20.52
614	5923138001031	03/28/23 - 03/28/23	05/22/23	3,358.00	0.00	0.00	0.00	606.75
615	2023142051525	05/17/23 - 05/17/23	05/29/23	2,296.00	0.00	0.00	0.00	414.85
618	2023142051525	05/17/23 - 05/17/23	05/29/23	0.00	3,469.00	0.00	0.00	0.00
618	2023142051525	05/17/23 - 05/17/23	05/29/23	0.00	3,471.00	0.00	0.00	0.00
614	2223146002699	05/04/23 - 05/04/23	05/29/23	2,296.00	0.00	0.00	0.00	414.85
780	2023156037686	05/03/23 - 05/03/23	06/12/23	38.00	0.00	0.00	0.00	20.52
780	2023164030823	05/10/23 - 05/10/23	06/19/23	38.00	0.00	0.00	0.00	20.52
614	2023168001343	06/02/23 - 06/02/23	06/26/23	564.00	0.00	0.00	0.00	101.91
615	2023185041219	06/07/23 - 06/07/23	07/10/23	2,296.00	0.00	0.00	0.00	414.85
614	2223186000665	10/04/22 - 10/04/22	07/10/23	2,296.00	0.00	0.00	0.00	414.85
614	2023194088304	07/10/23 - 07/10/23	07/17/23	564.00	0.00	0.00	0.00	101.91
614	2023198040369	07/12/23 - 07/12/23	07/24/23	564.00	0.00	0.00	0.00	101.91
614	2223206008689	01/18/23 - 01/18/23	07/31/23	2,296.00	0.00	0.00	0.00	414.85
618	2023222121740	08/07/23 - 08/07/23	08/14/23	0.00	3,187.00	0.00	0.00	0.00
614	2023233046470	08/18/23 - 08/18/23	08/28/23	564.00	0.00	0.00	0.00	101.91
614	2023240044957	08/23/23 - 08/23/23	09/04/23	564.00	0.00	0.00	0.00	101.91
614	2023240045684	08/25/23 - 08/25/23	09/04/23	564.00	0.00	0.00	0.00	101.91
615	2023254057037	08/14/23 - 08/14/23	09/18/23	2,296.00	0.00	0.00	0.00	501.17
615	2023254057037	08/14/23 - 08/14/23	09/18/23	2,296.00	0.00	0.00	0.00	501.17
614	2023276000206	08/23/23 - 08/23/23	10/09/23	564.00	0.00	0.00	0.00	123.11
618	2224025011362	08/27/23 - 08/27/23	01/29/24	0.00	3,469.00	0.00	0.00	0.00
TOTAL				266,437.00	68,806.00	0.00	80.98	49,264.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

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SERVICE DATES 09/01/22 THROUGH 08/31/23
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CHARGES		PAYMENTS	
TOTAL CHARGES	1,293,819.12	ADJUSTMENTS	0.00
COVERED CHARGES	581,866.68	CONTRACTUAL ALLOW	484,394.81
NON-COVERD CHARGES	711,952.44	TOTAL MEDICAID LIAB	97,471.87
		LESS: COB	97,471.87
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 179

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,960.30	11,301.03
MED/SURG SUPPLY	31,658.46	460.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,533.00	4,031.00
CT SCAN	24,235.00	30,738.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,324.00	408.00
IV THERAPY	16,596.00	1,224.00
OPERATING ROOM	74,566.00	252,209.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	991.00	0.00
ANESTHESIA	71,136.00	0.00
GI SERVICES	2,489.00	7,957.00
EMERGENCY ROOM	69,938.00	1,767.00
RECOVERY ROOM	42,722.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	25,457.00	4,760.00
OCCUPATIONAL THERAPY	0.00	712.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	1,256.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,896.00	15,817.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,994.00	4,264.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,760.00	87,368.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,260.00	803.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,493.00	11,688.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	118,626.00	50,234.00
MRI SERVICES	14,512.00	74,608.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,843.42	50,753.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	620.50	97,037.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	3,812.00

TOTAL ANCILLARY	581,866.68	711,952.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	581,866.68	711,952.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022354030005	12/06/22 - 12/06/22	12/26/22	0.00	3,812.00	0.00	37.25	0.00
TOTAL				0.00	3,812.00	0.00	37.25	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	399,421.15	ADJUSTMENTS	134.26
COVERED CHARGES	342,438.62	CONTRACTUAL ALLOW	333,510.33
NON-COVERD CHARGES	56,982.53	TOTAL MEDICAID LIAB	8,928.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,928.29

TOTAL NUMBER OF CLAIMS 133

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.62	3,351.73
MED/SURG SUPPLY	275.99	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,641.00	2,827.00
CT SCAN	28,395.00	31,089.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,812.00	0.00
IV THERAPY	8,621.00	0.00
OPERATING ROOM	2,130.00	987.00
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	194,804.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,466.00	8,842.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	3,497.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,144.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,201.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,271.00	5,203.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,220.01	972.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	213.74
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	342,438.62	56,982.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,438.62	56,982.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,058.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,246.00	CONTRACTUAL ALLOW	13,977.48
NON-COVERD CHARGES	1,812.00	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	204.00	0.00
IV THERAPY	684.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,000.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	780.00	1,620.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,471.00	192.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,246.00	1,812.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,246.00	1,812.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,124,900.22	ADJUSTMENTS	93,000.51
COVERED CHARGES	2,710,771.54	CONTRACTUAL ALLOW	2,345,141.17
NON-COVERD CHARGES	414,128.68	TOTAL MEDICAID LIAB	365,630.37
		LESS: COB	12,361.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	353,269.00

TOTAL NUMBER OF CLAIMS 55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,861.39	6,324.93
MED/SURG SUPPLY	148,667.28	26.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,405.00	17,287.00
CT SCAN	944.00	4,435.00
PHYSICAL THERAPY	0.00	7,403.00
EKG/ECG	612.00	0.00
IV THERAPY	1,308.00	0.00
OPERATING ROOM	1,210,076.25	116,992.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,980.00	2,272.00
ANESTHESIA	291,510.00	0.00
GI SERVICES	7,739.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	361,144.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	90,241.00	0.00
OCCUPATIONAL THERAPY	0.00	4,658.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,934.00	1,770.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,699.00	2,590.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	964.00	143.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	76,773.00	7,038.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	22,726.00	1,395.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	2,132.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,792.25	15,298.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,631.20	14,512.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	244,764.17	209,851.27
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,710,771.54	414,128.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,710,771.54	414,128.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,958.95	ADJUSTMENTS	0.00
COVERED CHARGES	77,907.48	CONTRACTUAL ALLOW	64,571.68
NON-COVERD CHARGES	2,051.47	TOTAL MEDICAID LIAB	13,335.80
		LESS: COB	13,335.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,850.07	140.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,702.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312.00	312.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	782.00	FEE SCHEDULE LAB	824.00	90.00
EKG/ECG	0.00	204.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,809.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	188.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,827.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,991.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	444.50	523.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,959.10	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	77,907.48	2,051.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,907.48	2,051.47

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,282,617.04	ADJUSTMENTS	157,027.91
COVERED CHARGES	5,282,617.04	CONTRACTUAL ALLOW	3,337,569.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,945,047.40
		LESS: COB	2,467.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,942,580.38

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,622	0	4,456,785.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,622	0	4,456,785.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,622	0	4,456,785.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,929.65	0.00	OTHER LAB	3,762.00	0.00
MED/SURG SUPPLY	6,864.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	298,925.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,867.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,794.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,470.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,437.00	0.00	INJECTABLE DRUGS	156,013.39	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	50,478.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	825,832.04	0.00
TOTAL ACCOMODATIONS	4,456,785.00	0.00
TOTAL CHARGES	5,282,617.04	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,514.23	ADJUSTMENTS	0.00
COVERED CHARGES	81,918.35	CONTRACTUAL ALLOW	57,155.47
NON-COVERD CHARGES	4,595.88	TOTAL MEDICAID LIAB	24,762.88
		LESS: COB	24,762.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	26	0	71,645.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	26	0	71,645.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	26	0	71,645.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	3,812.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,289.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,260.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,595.88
INJECTABLE DRUGS	3,912.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,273.35	4,595.88
TOTAL ACCOMODATIONS	71,645.00	0.00
TOTAL CHARGES	81,918.35	4,595.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/22	THROUGH	08/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,683,373.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,639,638.50	CONTRACTUAL ALLOW	1,322,690.35
NON-COVERD CHARGES	43,735.00	TOTAL MEDICAID LIAB	316,948.15
		LESS: COB	9,666.31
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	307,281.84

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	106	0	182,875.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	106	0	182,875.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	27	0	62,270.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	27	0	62,270.00	0.00
TOTAL ACCOMODATIONS	133	0	245,145.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	224,695.00	0.00
MED/SURG SUPPLY	140,643.50	0.00
LABORATORY-GENERAL	414,575.00	0.00
RADIOLOGY-DIAGNOSTIC	28,095.00	0.00
CT SCAN	173,355.00	12,240.00
PHYSICAL THERAPY	6,135.00	0.00
EKG/ECG	11,550.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	700.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	127,820.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	10,380.00	0.00
EMERGENCY ROOM	114,040.00	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 SERVICE	2,585.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,630.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,945.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	35,745.00	31,495.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,015.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,400.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,250.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,935.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,394,493.50	43,735.00
TOTAL ACCOMODATIONS	245,145.00	0.00
TOTAL CHARGES	1,639,638.50	43,735.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,569,936.05	ADJUSTMENTS	16,180.81
COVERED CHARGES	1,911,049.00	CONTRACTUAL ALLOW	1,626,716.85
NON-COVERD CHARGES	658,887.05	TOTAL MEDICAID LIAB	284,332.15
		LESS: COB	270.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	284,061.32
		ALL OTHER	260,934.95
		FEE SCHEDULE-LAB	22,215.84
		INJECTABLE DRUGS	910.53

TOTAL NUMBER OF CLAIMS 638

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,591.00	103,982.05
MED/SURG SUPPLY	83,033.00	15,520.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,305.00	9,145.00
CT SCAN	242,660.00	291,190.00
PHYSICAL THERAPY	197,125.00	14,235.00
EKG/ECG	25,370.00	1,980.00
IV THERAPY	0.00	0.00
OPERATING ROOM	53,900.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	18,285.00	8,815.00
ANESTHESIA	0.00	0.00
GI SERVICES	75,330.00	45,500.00
EMERGENCY ROOM	378,565.00	36,885.00
RECOVERY ROOM	3,025.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	32,220.00	6,365.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,175.00	1,070.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,465.00	8,730.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	142,090.00	17,845.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	25,125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,400.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	382,980.00	42,620.00
MRI SERVICES	68,990.00	5,250.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,690.00	48,355.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	125.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,911,049.00	658,887.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,911,049.00	658,887.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,040.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,205.00	CONTRACTUAL ALLOW	2,756.67
NON-COVERD CHARGES	9,835.00	TOTAL MEDICAID LIAB	448.33
		LESS: COB	448.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	235.00
MED/SURG SUPPLY	115.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	6,695.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,835.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,020.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	255.00	130.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,755.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,205.00	9,835.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,205.00	9,835.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	272,489.12	ADJUSTMENTS	0.00
COVERED CHARGES	190,210.00	CONTRACTUAL ALLOW	182,143.04
NON-COVERD CHARGES	82,279.12	TOTAL MEDICAID LIAB	8,066.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,066.96

TOTAL NUMBER OF CLAIMS 103

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895.00	5,534.12
MED/SURG SUPPLY	3,480.00	675.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,830.00	435.00
CT SCAN	13,260.00	50,650.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,930.00	330.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,445.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	102,320.00	1,665.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	46,315.00	12,720.00
MRI SERVICES	0.00	5,250.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,735.00	5,020.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	190,210.00	82,279.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190,210.00	82,279.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	72,170,324.54	ADJUSTMENTS	3,390,919.78
COVERED CHARGES	71,191,885.29	CONTRACTUAL ALLOW	57,084,379.15
NON-COVERD CHARGES	978,439.25	TOTAL MEDICAID LIAB	14,107,506.14
		LESS: COB	129,799.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	27,246.00
		REIMBURSEMENT	14,004,953.01

TOTAL NUMBER OF ADMISSIONS 1,563

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,064	0	3,552,432.00	0.00
ROUTINE NURSERY	1,220	0	1,450,072.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.51
TOTAL ROUTINE	5,284	0	5,002,504.00	0.51
SPECIAL CARE SERVICES				
CCU	2,128	0	3,102,297.00	0.00
ICU	1,635	0	2,633,233.00	0.00
NICU	14	0	33,344.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	6	0	21,372.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,783	0	5,790,246.00	0.00
TOTAL ACCOMODATIONS	9,067	0	10,792,750.00	0.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,515,562.64	61,650.50
MED/SURG SUPPLY	1,103,686.06	3,464.39
LABORATORY-GENERAL	15,418,769.38	19,135.00
RADIOLOGY-DIAGNOSTIC	1,422,019.00	712.00
CT SCAN	3,004,692.41	7,344.00
PHYSICAL THERAPY	291,929.00	237.00
EKG/ECG	482,519.00	420.00
IV THERAPY	1,261,140.00	740.00
OPERATING ROOM	7,340,914.85	0.00
LABOR/DELIVERY ROOM	1,200,027.00	25,597.00
RESPIRATORY SERVICES	5,044,623.00	12,509.00
ANESTHESIA	1,392,211.00	0.00
GI SERVICES	677,938.75	0.00
EMERGENCY ROOM	4,291,828.00	15,293.00
RECOVERY ROOM	1,195,482.80	0.00
LABORATORY PATHOLOGIC	286,627.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	279,268.00	0.00
SPEECH PATHOLOGY	109,087.00	0.00
RENAL DIALYSIS	326,908.00	3,679.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	24,467.00	28,132.00
PSYCHIATRIC SERVICES	7,046.00	0.00
LITHOTRIPSY	19,843.95	0.00
OTHER IMAGING SERVICE	674,986.00	64,515.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	243,722.00	166,456.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	210,465.02	31,554.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,939,821.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	45,310.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	764,212.05	161,541.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	423,919.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	752.00	0.00
OTHER THERAPEUTIC SVC	561,657.00	1,344.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	701,667.09	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	148,322.40
INJECTABLE DRUGS	1,615,468.80	4,144.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	221,648.00
IMPL DEV CHARGE PATIENTS	1,490,142.99	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	30,422.00	0.00

TOTAL ANCILLARY	60,399,135.29	978,438.74
TOTAL ACCOMODATIONS	10,792,750.00	0.51
TOTAL CHARGES	71,191,885.29	978,439.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023024051534	01/11/23 - 01/13/23	01/30/23	4,739.00	0.00	0.00	0.00	0.00
615	2023055090835	02/08/23 - 02/09/23	03/06/23	4,739.00	0.00	0.00	0.00	0.00
615	2023123089860	04/16/23 - 04/28/23	05/08/23	1,725.00	0.00	0.00	0.00	0.00
615	2223198000862	01/05/23 - 01/09/23	07/24/23	4,739.00	0.00	0.00	0.00	0.00
615	2223219004745	07/20/23 - 07/22/23	08/14/23	5,308.00	0.00	0.00	0.00	0.00
615	2023254030382	07/29/23 - 08/31/23	09/18/23	1,932.00	0.00	0.00	0.00	0.00
615	2023310031287	10/21/23 - 10/31/23	11/13/23	5,308.00	0.00	0.00	0.00	0.00
615	2223333000367	10/25/23 - 11/01/23	12/04/23	1,932.00	0.00	0.00	0.00	0.00
24	2024050031496	07/28/23 - 08/19/23	02/26/24	0.00	0.00	0.00	0.00	0.00
TOTAL				30,422.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	781,638.92	ADJUSTMENTS	0.00
COVERED CHARGES	779,566.92	CONTRACTUAL ALLOW	678,493.33
NON-COVERD CHARGES	2,072.00	TOTAL MEDICAID LIAB	101,073.59
		LESS: COB	101,136.59
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	55	0	47,800.00	0.00
ROUTINE NURSERY	12	0	15,510.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	63,310.00	0.00
SPECIAL CARE SERVICES				
CCU	44	0	65,229.00	0.00
ICU	15	0	20,545.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	59	0	85,774.00	0.00
TOTAL ACCOMODATIONS	126	0	149,084.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,361.30	0.00	OTHER LAB	4,072.00	0.00
MED/SURG SUPPLY	19,922.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	176,030.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,562.00	0.00	OTHER THERAPEUTIC SVC	4,402.00	0.00
CT SCAN	19,407.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,342.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,895.00	0.00	MRI SERVICES	7,008.00	0.00
IV THERAPY	12,042.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,833.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,768.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,105.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,354.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,318.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,528.00	0.00	INJECTABLE DRUGS	15,469.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,765.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,987.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	152.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,386.17	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	7,597.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	993.00	722.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,943.00	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/OBSERV. RM	5,641.75	1,350.00			

TOTAL ANCILLARY	630,482.92	2,072.00
TOTAL ACCOMODATIONS	149,084.00	0.00
TOTAL CHARGES	779,566.92	2,072.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,385,798.05	ADJUSTMENTS	753,736.86
COVERED CHARGES	36,204,553.38	CONTRACTUAL ALLOW	31,492,004.58
NON-COVERD CHARGES	4,181,244.67	TOTAL MEDICAID LIAB	4,712,548.80
		LESS: COB	26,418.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,686,130.06
		ALL OTHER	3,807,090.46
		FEE SCHEDULE-LAB	470,253.77
		INJECTABLE DRUGS	408,785.83

TOTAL NUMBER OF CLAIMS 9,009

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317,514.45	0.00
MED/SURG SUPPLY	631,672.12	4,628.16
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,361,321.00	23,836.00
CT SCAN	2,790,440.00	529,899.00
PHYSICAL THERAPY	117,109.00	37,790.00
EKG/ECG	334,142.00	13,343.00
IV THERAPY	1,181,127.00	63,176.00
OPERATING ROOM	3,412,871.10	981,984.90
LABOR/DELIVERY ROOM	2,464.00	0.00
RESPIRATORY SERVICES	306,646.00	27,674.00
ANESTHESIA	551,203.00	2,473.00
GI SERVICES	383,299.00	58,112.25
EMERGENCY ROOM	7,902,991.00	13,816.00
RECOVERY ROOM	784,670.85	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	87,682.00	0.00
OCCUPATIONAL THERAPY	5,684.00	7,412.00
SPEECH PATHOLOGY	363.00	9,258.00
RENAL DIALYSIS	0.00	309,408.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	997,666.00	207,278.10
PSYCHIATRIC SERVICES	318.00	95,207.00
LITHOTRIPSY	19,843.95	0.00
OTHER IMAGING SERVICE	579,480.00	126,884.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	57,605.00	28,722.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	251,682.00	72,802.30
AUDIOLOGY	0.00	0.00
CARDIOLOGY	603,262.00	178,192.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	310,852.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	750,163.85	29,201.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	251,101.00	5,681.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,356.00
OTHER THERAPEUTIC SVC	766,277.00	164,882.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,238,296.66	208,634.14
MRI SERVICES	539,067.00	99,030.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	133,021.90
INJECTABLE DRUGS	3,601,062.45	497,275.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	237,024.00
IMPL DEV CHARGE PATIENTS	66,676.95	3,069.40
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	10,174.00

TOTAL ANCILLARY	36,204,553.38	4,181,244.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,204,553.38	4,181,244.67

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5923195001378	05/30/23 - 05/30/23	07/24/23	0.00	5,806.00	0.00	0.00	0.00
614	5923195001378	05/30/23 - 05/30/23	07/24/23	0.00	300.00	0.00	0.00	0.00
615	2023264098457	09/15/23 - 09/15/23	09/25/23	0.00	1,932.00	0.00	0.00	0.00
615	5923346000812	11/21/23 - 11/21/23	12/18/23	0.00	1,932.00	0.00	0.00	0.00
780	2024260027071	11/27/23 - 11/27/23	09/23/24	0.00	204.00	0.00	0.00	0.00
TOTAL				0.00	10,174.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	927,068.06	ADJUSTMENTS	0.00
COVERED CHARGES	696,423.86	CONTRACTUAL ALLOW	608,848.13
NON-COVERD CHARGES	230,644.20	TOTAL MEDICAID LIAB	87,575.73
		LESS: COB	87,575.73
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 153

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,747.90	0.00
MED/SURG SUPPLY	12,653.75	75.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,049.00	0.00
CT SCAN	8,105.00	73,650.00
PHYSICAL THERAPY	1,331.00	1,435.00
EKG/ECG	5,565.00	0.00
IV THERAPY	14,511.00	0.00
OPERATING ROOM	53,465.00	74,466.00
LABOR/DELIVERY ROOM	1,800.00	0.00
RESPIRATORY SERVICES	3,534.00	600.00
ANESTHESIA	14,191.00	0.00
GI SERVICES	0.00	8,820.00
EMERGENCY ROOM	277,027.00	0.00
RECOVERY ROOM	11,618.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,516.00	0.00
OCCUPATIONAL THERAPY	106.00	1,820.00
SPEECH PATHOLOGY	0.00	619.00
RENAL DIALYSIS	0.00	12,992.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,876.00	10,731.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,800.00	630.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,974.00	11,021.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,435.10	3,652.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,079.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	18,975.00	2,600.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	194,495.50	4,019.00
MRI SERVICES	2,790.00	11,822.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,078.60
INJECTABLE DRUGS	12,136.55	1,789.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	5,824.00
IMPL DEV CHARGE PATIENTS	642.56	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	696,423.86	230,644.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	696,423.86	230,644.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	833,342.90	ADJUSTMENTS	268.52
COVERED CHARGES	803,439.00	CONTRACTUAL ALLOW	788,066.23
NON-COVERD CHARGES	29,903.90	TOTAL MEDICAID LIAB	15,372.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,372.77

TOTAL NUMBER OF CLAIMS 229

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,974.65	0.00
MED/SURG SUPPLY	815.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,349.00	1,299.00
CT SCAN	13,317.00	12,037.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,760.00	0.00
IV THERAPY	5,745.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	468,553.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	210.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,370.00	3,682.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,450.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,741.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	23,941.00	1,266.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	233,212.45	9,144.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,000.50	2,475.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	803,439.00	29,903.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	803,439.00	29,903.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	72,426.40	ADJUSTMENTS	0.00
COVERED CHARGES	55,108.40	CONTRACTUAL ALLOW	54,369.97
NON-COVERD CHARGES	17,318.00	TOTAL MEDICAID LIAB	738.43
		LESS: COB	738.43
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.00	0.00
MED/SURG SUPPLY	1,630.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,888.00	0.00
CT SCAN	2,352.00	13,992.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	420.00	0.00
IV THERAPY	1,075.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,498.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,393.00	1,533.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	1,793.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,318.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,275.55	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,246.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	55,108.40	17,318.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,108.40	17,318.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,487,537.27	ADJUSTMENTS	113,787.40
COVERED CHARGES	12,799,175.95	CONTRACTUAL ALLOW	12,061,642.22
NON-COVERD CHARGES	688,361.32	TOTAL MEDICAID LIAB	737,533.73
		LESS: COB	4,969.96
		LESS: COPAYMENT	375.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	732,188.77

TOTAL NUMBER OF CLAIMS 130

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,647.00	6,932.70
MED/SURG SUPPLY	308,119.55	6,559.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,266.00	1,424.00
CT SCAN	45,552.00	10,965.00
PHYSICAL THERAPY	0.00	1,841.00
EKG/ECG	6,315.00	1,920.00
IV THERAPY	61,600.00	17,955.00
OPERATING ROOM	3,634,349.77	249,565.73
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31,467.00	212.00
ANESTHESIA	544,339.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	73,284.00	3,591.00
RECOVERY ROOM	449,191.85	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,177.00	0.00
OCCUPATIONAL THERAPY	0.00	949.00
SPEECH PATHOLOGY	816.00	3,193.00
RENAL DIALYSIS	0.00	1,856.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,997.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	50,740.00	17,453.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,058.00	722.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	519.00	14,199.85
AUDIOLOGY	0.00	0.00
CARDIOLOGY	277,772.00	116,137.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	43,376.30	5,626.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,571.00	62,041.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	23,025.00	24,451.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	196,089.00	20,349.57
MRI SERVICES	11,685.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	845.45
INJECTABLE DRUGS	1,133,004.85	116,346.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,703,214.63	3,226.27
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,799,175.95	688,361.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,799,175.95	688,361.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	811,358.04	ADJUSTMENTS	0.00
COVERED CHARGES	786,105.04	CONTRACTUAL ALLOW	773,462.07
NON-COVERD CHARGES	25,253.00	TOTAL MEDICAID LIAB	12,642.97
		LESS: COB	12,642.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,220.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,529.69	30.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	431.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,299.00	25,223.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,135.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	504.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	744,648.80	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	786,105.04	25,253.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	786,105.04	25,253.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,893,053.63	ADJUSTMENTS	2,886,630.14
COVERED CHARGES	48,535,230.13	CONTRACTUAL ALLOW	40,650,377.62
NON-COVERD CHARGES	357,823.50	TOTAL MEDICAID LIAB	7,884,852.51
		LESS: COB	163,289.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,721,563.09

TOTAL NUMBER OF ADMISSIONS 854

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,166	0	6,462,732.00	0.00
ROUTINE NURSERY	1,188	0	3,655,849.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,354	0	10,118,581.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	477	0	2,613,823.00	0.00
NICU	129	0	1,099,904.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	606	0	3,713,727.00	0.00
TOTAL ACCOMODATIONS	4,960	0	13,832,308.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,788,673.92	49,189.00
MED/SURG SUPPLY	926,388.00	8,847.00
LABORATORY-GENERAL	7,050,664.21	86.00
RADIOLOGY-DIAGNOSTIC	581,314.00	0.00
CT SCAN	1,919,762.00	0.00
PHYSICAL THERAPY	613,760.00	0.00
EKG/ECG	182,728.00	0.00
IV THERAPY	53,029.00	0.00
OPERATING ROOM	3,067,457.00	1,275.00
LABOR/DELIVERY ROOM	1,082,686.00	0.00
RESPIRATORY SERVICES	1,541,172.00	0.00
ANESTHESIA	575,169.00	0.00
GI SERVICES	40,188.00	0.00
EMERGENCY ROOM	1,428,851.00	0.00
RECOVERY ROOM	412,236.00	0.00
LABORATORY PATHOLOGIC	499,664.00	0.00
RADIOLOGY THERAPEUTIC	165,292.00	0.00
OCCUPATIONAL THERAPY	512,022.00	0.00
SPEECH PATHOLOGY	208,108.00	0.00
RENAL DIALYSIS	328,400.00	104,764.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	182.00	258.00
PSYCHIATRIC SERVICES	561.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	251,967.00	73,728.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	457,192.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	150,358.00	20,510.00
AUDIOLOGY	108,409.00	0.00
CARDIOLOGY	1,300,358.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	41,439.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	112,616.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	212,505.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,908.00	0.00
OTHER THERAPEUTIC SVC	0.00	8,588.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	526,057.00	25,514.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	998.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	14,911.00
DRUG-SPECIFIC/HOME IV	0.00	49,155.50
INJECTABLE DRUGS	3,922,315.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,639,491.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,702,922.13	357,823.50
TOTAL ACCOMODATIONS	13,832,308.00	0.00
TOTAL CHARGES	48,535,230.13	357,823.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,890,938.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,881,523.00	CONTRACTUAL ALLOW	1,701,859.23
NON-COVERD CHARGES	9,415.00	TOTAL MEDICAID LIAB	179,663.77
		LESS: COB	179,663.77
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	53	0	93,390.00	0.00
ROUTINE NURSERY	67	0	335,030.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	120	0	428,420.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	13	0	67,678.00	0.00
NICU	58	0	498,394.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	71	0	566,072.00	0.00
TOTAL ACCOMODATIONS	191	0	994,492.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,663.00	0.00
MED/SURG SUPPLY	44,633.00	0.00
LABORATORY-GENERAL	139,897.00	0.00
RADIOLOGY-DIAGNOSTIC	31,626.00	0.00
CT SCAN	3,585.00	0.00
PHYSICAL THERAPY	3,402.00	0.00
EKG/ECG	936.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	106,840.00	0.00
LABOR/DELIVERY ROOM	84,925.00	0.00
RESPIRATORY SERVICES	205,303.00	0.00
ANESTHESIA	9,048.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,593.00	0.00
RECOVERY ROOM	17,719.00	0.00
LABORATORY PATHOLOGIC	6,818.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,064.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,285.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,496.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	4,744.00	0.00
CARDIOLOGY	17,749.00	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	106.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,034.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	7,381.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	54,580.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,019.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	887,031.00	9,415.00
TOTAL ACCOMODATIONS	994,492.00	0.00
TOTAL CHARGES	1,881,523.00	9,415.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,168,750.43	ADJUSTMENTS	466,134.34
COVERED CHARGES	14,462,184.09	CONTRACTUAL ALLOW	12,378,576.07
NON-COVERD CHARGES	1,706,566.34	TOTAL MEDICAID LIAB	2,083,608.02
		LESS: COB	2,535.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,081,072.64
		ALL OTHER	1,848,602.82
		FEE SCHEDULE-LAB	121,213.43
		INJECTABLE DRUGS	111,256.39

TOTAL NUMBER OF CLAIMS 2,690

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	676,887.00	15,325.50
MED/SURG SUPPLY	165,455.00	13,047.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	396,091.00	7,596.00
CT SCAN	1,924,135.00	194,451.00
PHYSICAL THERAPY	393,735.00	22,448.00
EKG/ECG	57,610.00	1,404.00
IV THERAPY	482,767.00	5,783.00
OPERATING ROOM	1,168,988.16	211,669.84
LABOR/DELIVERY ROOM	7,459.00	0.00
RESPIRATORY SERVICES	98,836.00	4,060.00
ANESTHESIA	281,903.00	0.00
GI SERVICES	5,865.00	0.00
EMERGENCY ROOM	1,867,151.00	4,111.00
RECOVERY ROOM	236,652.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,379,084.00	353,021.00
OCCUPATIONAL THERAPY	76,772.00	28,638.00
SPEECH PATHOLOGY	13,927.00	11,234.00
RENAL DIALYSIS	0.00	72,248.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	65,056.00	0.00
PSYCHIATRIC SERVICES	3,927.00	7,854.00
LITHOTRIPSY	29,804.00	0.00
OTHER IMAGING SERVICE	697,345.00	74,970.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	142,571.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	52,773.00	22,007.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	121,171.00	34,784.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,390.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	54,449.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	196,045.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	243.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,623,903.99	112,687.00
MRI SERVICES	1,055,048.00	44,364.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	497.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	480.00
DRUG-SPECIFIC/HOME IV	0.00	5,077.00
INJECTABLE DRUGS	1,103,434.50	456,728.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	69,706.00	2,082.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,462,184.09	1,706,566.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,462,184.09	1,706,566.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	794,420.50	ADJUSTMENTS	0.00
COVERED CHARGES	441,047.50	CONTRACTUAL ALLOW	380,446.18
NON-COVERD CHARGES	353,373.00	TOTAL MEDICAID LIAB	60,601.32
		LESS: COB	60,601.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,431.00	524.00
MED/SURG SUPPLY	15,676.00	7,821.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,421.00	0.00
CT SCAN	56,757.00	27,034.00
PHYSICAL THERAPY	0.00	1,743.00
EKG/ECG	3,744.00	0.00
IV THERAPY	15,167.00	511.00
OPERATING ROOM	37,390.00	137,592.00
LABOR/DELIVERY ROOM	2,117.00	0.00
RESPIRATORY SERVICES	635.00	0.00
ANESTHESIA	35,623.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	68,980.00	1,406.00
RECOVERY ROOM	16,820.00	2,124.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	23,544.00	39,816.00
OCCUPATIONAL THERAPY	0.00	1,472.00
SPEECH PATHOLOGY	0.00	868.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	129.00
PSYCHIATRIC SERVICES	0.00	561.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,642.00	32,475.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	3,273.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	3,436.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,606.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,301.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	76,320.00	13,868.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,023.50	14,575.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,850.00	64,145.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	441,047.50	353,373.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	441,047.50	353,373.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	368,280.00	ADJUSTMENTS	537.04
COVERED CHARGES	342,402.00	CONTRACTUAL ALLOW	336,360.30
NON-COVERD CHARGES	25,878.00	TOTAL MEDICAID LIAB	6,041.70
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,041.70

TOTAL NUMBER OF CLAIMS 90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,862.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,922.00	0.00
CT SCAN	27,030.00	14,930.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,299.00	0.00
IV THERAPY	17,291.00	0.00
OPERATING ROOM	345.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	635.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	178,870.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	561.00	561.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,323.00	1,235.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	59,920.00	352.00
MRI SERVICES	5,373.00	6,669.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,971.00	2,131.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	342,402.00	25,878.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,402.00	25,878.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,906.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,276.00	CONTRACTUAL ALLOW	31,738.96
NON-COVERD CHARGES	5,630.00	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,028.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,302.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,337.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,061.00	188.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,997.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,989.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	997.50	105.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	901.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,276.00	5,630.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,276.00	5,630.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,115,049.40	ADJUSTMENTS	93,152.20
COVERED CHARGES	3,728,382.91	CONTRACTUAL ALLOW	3,396,528.15
NON-COVERD CHARGES	386,666.49	TOTAL MEDICAID LIAB	331,854.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	331,854.76

TOTAL NUMBER OF CLAIMS 57

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,763.50	0.00
MED/SURG SUPPLY	250,422.00	8,207.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,865.00	1,504.00
CT SCAN	6,146.00	0.00
PHYSICAL THERAPY	496.00	18,868.00
EKG/ECG	10,742.00	468.00
IV THERAPY	1,055.00	0.00
OPERATING ROOM	1,058,250.51	98,869.49
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,905.00	0.00
ANESTHESIA	230,960.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,393.00	0.00
RECOVERY ROOM	154,160.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	328,132.00	71,207.00
OCCUPATIONAL THERAPY	0.00	2,822.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	6,732.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	914.00	1,136.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	348.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,152.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	164,807.00	53,856.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	18,964.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,182.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	79,582.00	1,581.00
MRI SERVICES	6,606.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	188,790.50	85,548.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,085,747.00	35,868.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,728,382.91	386,666.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,728,382.91	386,666.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	137,614.50	ADJUSTMENTS	0.00
COVERED CHARGES	41,041.50	CONTRACTUAL ALLOW	35,219.50
NON-COVERD CHARGES	96,573.00	TOTAL MEDICAID LIAB	5,822.00
		LESS: COB	5,822.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,577.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,393.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	759.00	49.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	16,984.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,997.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	997.50	2,047.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,052.00	77,493.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,914.00	0.00			

TOTAL ANCILLARY	41,041.50	96,573.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,041.50	96,573.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,061,759.29	ADJUSTMENTS	155,256.64
COVERED CHARGES	17,954,910.36	CONTRACTUAL ALLOW	15,485,502.30
NON-COVERD CHARGES	106,848.93	TOTAL MEDICAID LIAB	2,469,408.06
		LESS: COB	3,946.29
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,158.00
		REIMBURSEMENT	2,469,619.77

TOTAL NUMBER OF ADMISSIONS 311

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	422	0	877,576.74	0.00
ROUTINE NURSERY	144	0	190,896.80	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	566	0	1,068,473.54	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	692	0	2,569,810.82	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	692	0	2,569,810.82	0.00
TOTAL ACCOMODATIONS	1,258	0	3,638,284.36	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	992,399.68	958.87
MED/SURG SUPPLY	206,567.30	0.00
LABORATORY-GENERAL	2,875,756.07	12,654.84
RADIOLOGY-DIAGNOSTIC	258,095.47	768.09
CT SCAN	582,508.36	11,436.98
PHYSICAL THERAPY	123,600.06	0.00
EKG/ECG	184,289.78	736.65
IV THERAPY	149,990.84	0.00
OPERATING ROOM	1,313,367.83	0.00
LABOR/DELIVERY ROOM	225,055.20	0.00
RESPIRATORY SERVICES	1,737,061.54	4,139.64
ANESTHESIA	404,162.11	0.00
GI SERVICES	19,093.00	0.00
EMERGENCY ROOM	641,628.45	0.00
RECOVERY ROOM	173,514.00	0.00
LABORATORY PATHOLOGIC	68,831.53	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	22,285.06	0.00
SPEECH PATHOLOGY	24,961.62	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	362.28	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	49,512.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,026.91	53,367.56
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	112,099.84	13,472.25
AUDIOLOGY	25,328.46	0.00
CARDIOLOGY	1,158,342.02	5,832.76
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,028.05	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,360.29	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	63,277.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	129,604.69	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,639,427.77	3,481.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	28,594.54	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	59,493.30	0.00

TOTAL ANCILLARY	14,316,626.00	106,848.93
TOTAL ACCOMODATIONS	3,638,284.36	0.00
TOTAL CHARGES	17,954,910.36	106,848.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023029003421	01/15/23 - 01/21/23	02/06/23	3,386.20	0.00	0.00	0.00	0.00
614	2023066068624	02/06/23 - 02/10/23	03/13/23	4,814.52	0.00	0.00	0.00	0.00
615	2023106002903	04/03/23 - 04/07/23	04/24/23	3,386.20	0.00	0.00	0.00	0.00
614	2223123009305	04/03/23 - 04/05/23	05/08/23	5,320.00	0.00	0.00	0.00	0.00
614	2223151009311	03/19/23 - 03/20/23	06/05/23	5,103.65	0.00	0.00	0.00	0.00
614	2023161028649	02/15/23 - 02/23/23	06/19/23	11,434.82	0.00	0.00	0.00	0.00
615	2023221008179	07/27/23 - 07/29/23	08/14/23	5,791.06	0.00	0.00	0.00	0.00
614	2223242004135	04/25/23 - 04/29/23	09/04/23	5,103.65	0.00	0.00	0.00	0.00
614	2023288004447	10/03/23 - 10/09/23	10/23/23	4,513.20	0.00	0.00	0.00	0.00
614	2023317034624	11/07/23 - 11/07/23	11/20/23	5,320.00	0.00	0.00	0.00	0.00
614	2023342076923	11/20/23 - 11/29/23	12/18/23	5,320.00	0.00	0.00	0.00	0.00
TOTAL				59,493.30	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,859.40	ADJUSTMENTS	0.00
COVERED CHARGES	139,859.40	CONTRACTUAL ALLOW	115,518.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	24,340.84
		LESS: COB	24,466.84
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	126.00
		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	6	0	10,524.84	0.00
ROUTINE NURSERY	6	0	7,879.26	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	18,404.10	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	18,404.10	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,416.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,767.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,054.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,596.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,567.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,270.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,628.76	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	222.98	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,181.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,516.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,218.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,313.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,055.23	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	713.97	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	642.06	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	121,455.30	0.00
TOTAL ACCOMODATIONS	18,404.10	0.00
TOTAL CHARGES	139,859.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,127,182.33	ADJUSTMENTS	492,811.63
COVERED CHARGES	22,553,892.34	CONTRACTUAL ALLOW	20,153,589.16
NON-COVERD CHARGES	3,573,289.99	TOTAL MEDICAID LIAB	2,400,303.18
		LESS: COB	2,936.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,397,366.24
		ALL OTHER	1,719,003.05
		FEE SCHEDULE-LAB	153,123.35
		INJECTABLE DRUGS	525,239.84

TOTAL NUMBER OF CLAIMS 3,978

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162,393.34	73,463.50
MED/SURG SUPPLY	352,737.21	97,727.49
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	512,094.50	10,558.28
CT SCAN	1,673,884.74	552,904.58
PHYSICAL THERAPY	358,654.77	48,393.48
EKG/ECG	402,553.86	16,493.60
IV THERAPY	1,086,858.29	53,580.82
OPERATING ROOM	2,251,221.10	451,703.87
LABOR/DELIVERY ROOM	7,294.24	0.00
RESPIRATORY SERVICES	231,318.23	87,268.13
ANESTHESIA	761,850.10	0.00
GI SERVICES	127,379.75	38,945.25
EMERGENCY ROOM	2,985,746.60	7,084.83
RECOVERY ROOM	732,967.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	327,778.07	267,675.53
OCCUPATIONAL THERAPY	0.00	840.84
SPEECH PATHOLOGY	201.95	4,456.34
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	15,410.70	0.00
CLINIC SERVICES	244.96	1,640.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	277,757.77	21,624.91
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	48,363.26	4,050.36
ONCOLOGY	10,450.00	0.00
NUCLEAR MEDICINE	348,201.46	79,623.12
AUDIOLOGY	0.00	0.00
CARDIOLOGY	706,081.80	80,863.10
AMBULATORY SURGERY	330.16	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	264,258.65	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	182,559.92	4,558.93

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	158,487.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,909.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,080,310.91	211,196.29
MRI SERVICES	239,195.12	19,097.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,093,629.16	773,101.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,077.46	657,655.96
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	150,599.51	4,871.79

TOTAL ANCILLARY	22,553,892.34	3,573,289.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,553,892.34	3,573,289.99

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023011076923	01/05/23 - 01/05/23	01/16/23	6,331.17	0.00	0.00	0.00	797.58
614	2023054101250	02/17/23 - 02/17/23	02/27/23	5,765.83	0.00	0.00	0.00	726.36
614	2023060074922	02/24/23 - 02/24/23	03/06/23	5,261.25	0.00	0.00	0.00	662.80
614	2023066068727	03/01/23 - 03/01/23	03/13/23	4,154.89	0.00	0.00	0.00	523.42
614	2023066068737	03/03/23 - 03/03/23	03/13/23	3,817.93	0.00	0.00	0.00	480.97
614	2023108066297	04/11/23 - 04/11/23	04/24/23	4,154.89	0.00	0.00	0.00	523.42
614	2023115057054	03/30/23 - 03/30/23	05/01/23	0.00	4,758.79	0.00	0.00	0.00
325	5923118000525	01/10/23 - 01/10/23	05/01/23	0.00	113.00	0.00	0.00	0.00
614	2023126031034	05/02/23 - 05/02/23	05/15/23	4,513.20	0.00	0.00	0.00	568.56
614	2023134003067	05/10/23 - 05/10/23	05/22/23	3,236.64	0.00	0.00	0.00	407.75
614	2023139103703	05/15/23 - 05/15/23	05/22/23	5,279.63	0.00	0.00	0.00	665.12
614	5923158113377	04/05/23 - 04/05/23	06/12/23	5,103.65	0.00	0.00	0.00	642.94
614	2023163027686	06/08/23 - 06/08/23	06/19/23	5,103.65	0.00	0.00	0.00	642.94
614	2023167068801	06/12/23 - 06/12/23	06/26/23	3,236.64	0.00	0.00	0.00	407.75
614	2023177004967	06/21/23 - 06/21/23	07/03/23	3,236.64	0.00	0.00	0.00	407.75
614	2023202062629	07/17/23 - 07/17/23	07/31/23	5,279.63	0.00	0.00	0.00	665.12
614	2023203028605	07/18/23 - 07/18/23	07/31/23	5,279.63	0.00	0.00	0.00	665.12
614	2023206055735	07/17/23 - 07/17/23	07/31/23	5,103.65	0.00	0.00	0.00	642.94
614	2223233003548	03/21/23 - 03/21/23	08/28/23	4,154.89	0.00	0.00	0.00	523.42
614	2023240027359	08/24/23 - 08/24/23	09/04/23	5,279.63	0.00	0.00	0.00	665.12
614	2023259026044	09/12/23 - 09/12/23	09/25/23	5,279.63	0.00	0.00	0.00	577.69
614	2023264098314	08/25/23 - 08/25/23	09/25/23	5,103.65	0.00	0.00	0.00	558.44
614	2023294023121	10/17/23 - 10/17/23	10/30/23	5,279.63	0.00	0.00	0.00	577.69
614	2023296041293	10/19/23 - 10/19/23	10/30/23	6,328.05	0.00	0.00	0.00	692.40
614	2023296041295	10/19/23 - 10/19/23	10/30/23	4,154.89	0.00	0.00	0.00	454.62
614	2023300085525	10/23/23 - 10/23/23	11/06/23	5,103.65	0.00	0.00	0.00	558.44
614	2023315039278	11/07/23 - 11/07/23	11/20/23	3,236.64	0.00	0.00	0.00	354.14
614	2023321069813	11/13/23 - 11/13/23	11/27/23	4,154.89	0.00	0.00	0.00	454.62
614	2023324029229	11/16/23 - 11/16/23	11/27/23	5,279.63	0.00	0.00	0.00	577.69
614	2023324029238	11/16/23 - 11/16/23	11/27/23	5,279.63	0.00	0.00	0.00	577.69
614	2023328050491	11/20/23 - 11/20/23	11/27/23	6,328.05	0.00	0.00	0.00	692.40
614	2023365002462	12/27/23 - 12/27/23	01/08/24	4,154.89	0.00	0.00	0.00	454.62
614	2024002038442	12/28/23 - 12/28/23	01/08/24	3,236.64	0.00	0.00	0.00	354.14
615	5924047000504	12/09/23 - 12/09/23	02/19/24	3,386.20	0.00	0.00	0.00	370.51
TOTAL				150,599.51	4,871.79	0.00	0.00	17,874.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	267,651.18	ADJUSTMENTS	0.00
COVERED CHARGES	193,100.69	CONTRACTUAL ALLOW	173,268.05
NON-COVERD CHARGES	74,550.49	TOTAL MEDICAID LIAB	19,832.64
		LESS: COB	19,832.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,418.09	350.30
MED/SURG SUPPLY	7,340.95	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,962.59	0.00
CT SCAN	889.48	35,525.96
PHYSICAL THERAPY	795.17	0.00
EKG/ECG	2,946.60	0.00
IV THERAPY	11,679.74	2,616.40
OPERATING ROOM	44,300.45	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	16,163.68	0.00
GI SERVICES	0.00	3,905.00
EMERGENCY ROOM	39,481.90	0.00
RECOVERY ROOM	16,881.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,864.90	1,840.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,794.53	2,021.68
MRI SERVICES	5,501.85	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,079.76	20,776.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	7,514.75
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	193,100.69	74,550.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	193,100.69	74,550.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	487,468.08	ADJUSTMENTS	469.91
COVERED CHARGES	453,925.51	CONTRACTUAL ALLOW	444,460.18
NON-COVERD CHARGES	33,542.57	TOTAL MEDICAID LIAB	9,465.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,465.33

TOTAL NUMBER OF CLAIMS 141

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	729.24	985.00
MED/SURG SUPPLY	0.00	247.69
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,897.73	338.46
CT SCAN	51,444.08	18,798.85
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,629.85	0.00
IV THERAPY	30,960.78	907.10
OPERATING ROOM	3,231.64	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	236,262.53	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,206.19	2,538.19
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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,916.67	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	87,260.96	7,474.84
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,385.84	2,252.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	453,925.51	33,542.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	453,925.51	33,542.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,099.10	ADJUSTMENTS	0.00
COVERED CHARGES	18,973.55	CONTRACTUAL ALLOW	18,772.16
NON-COVERD CHARGES	3,125.55	TOTAL MEDICAID LIAB	201.39
		LESS: COB	201.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	6,084.98	2,471.62
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,606.12	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,492.96	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,732.83	653.93
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56.66	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,973.55	3,125.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,973.55	3,125.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,367,767.69	ADJUSTMENTS	112,736.85
COVERED CHARGES	4,842,319.10	CONTRACTUAL ALLOW	4,401,186.60
NON-COVERD CHARGES	1,525,448.59	TOTAL MEDICAID LIAB	441,132.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	441,132.50

TOTAL NUMBER OF CLAIMS 82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,578.23	4,162.44
MED/SURG SUPPLY	415,750.73	16,803.62
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,947.51	4,317.33
CT SCAN	6,365.30	3,596.63
PHYSICAL THERAPY	0.00	17,195.91
EKG/ECG	5,893.20	736.65
IV THERAPY	73,819.73	9,047.64
OPERATING ROOM	2,121,353.95	136,624.43
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,961.62	0.00
ANESTHESIA	435,718.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,775.38	0.00
RECOVERY ROOM	210,236.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	41,209.38	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,604.50	1,550.33
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	95,699.45	95,842.49
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,337.97	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	93,612.96	10,689.71
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,187,120.28	127,353.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	16,334.89	1,097,528.08
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,842,319.10	1,525,448.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,842,319.10	1,525,448.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC.
1035 RED BUD RD NE
CALHOUN,GA 30701-2082

PROVIDER NUMBER
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,668,237.33	ADJUSTMENTS	23,974.74
COVERED CHARGES	1,661,744.51	CONTRACTUAL ALLOW	1,114,564.41
NON-COVERD CHARGES	6,492.82	TOTAL MEDICAID LIAB	547,180.10
		LESS: COB	7,695.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,772.00
		REIMBURSEMENT	542,256.89

TOTAL NUMBER OF ADMISSIONS 128

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	217	0	169,260.00	0.00
ROUTINE NURSERY	88	0	38,720.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	305	0	207,980.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	32	0	52,200.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	32	0	52,200.00	0.00
TOTAL ACCOMODATIONS	337	0	260,180.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,817.84	0.00
MED/SURG SUPPLY	61,322.04	0.00
LABORATORY-GENERAL	239,135.41	0.00
RADIOLOGY-DIAGNOSTIC	12,597.77	0.00
CT SCAN	64,831.44	0.00
PHYSICAL THERAPY	11,034.11	0.00
EKG/ECG	12,144.56	0.00
IV THERAPY	34,349.81	0.00
OPERATING ROOM	206,521.76	0.00
LABOR/DELIVERY ROOM	176,314.72	0.00
RESPIRATORY SERVICES	99,209.83	0.00
ANESTHESIA	19,790.24	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	111,491.05	0.00
RECOVERY ROOM	56,962.90	0.00
LABORATORY PATHOLOGIC	2,668.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	223.04	0.00
SPEECH PATHOLOGY	5,081.23	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,719.26	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,945.98	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,488.50	1,314.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,393.30	111.02
AUDIOLOGY	12,098.10	0.00
CARDIOLOGY	12,248.60	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/OBSERV. RM	48,882.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,837.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,027.35	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,089.69	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	5,067.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	55,337.76	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,401,564.51	6,492.82
TOTAL ACCOMODATIONS	260,180.00	0.00
TOTAL CHARGES	1,661,744.51	6,492.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,787.98	ADJUSTMENTS	0.00
COVERED CHARGES	14,787.98	CONTRACTUAL ALLOW	8,887.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,900.81
		LESS: COB	5,900.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,560.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,560.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,560.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,408.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	394.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	816.19	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,201.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,579.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,535.52	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,766.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	665.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	160.16	0.00	INJECTABLE DRUGS	98.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	147.63	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	454.37	0.00			

TOTAL ANCILLARY	13,227.98	0.00
TOTAL ACCOMODATIONS	1,560.00	0.00
TOTAL CHARGES	14,787.98	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,998,757.88	ADJUSTMENTS	58,934.13
COVERED CHARGES	2,855,438.27	CONTRACTUAL ALLOW	2,228,903.97
NON-COVERD CHARGES	143,319.61	TOTAL MEDICAID LIAB	626,534.30
		LESS: COB	1,528.58
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	625,005.72
		ALL OTHER	533,384.16
		FEE SCHEDULE-LAB	77,222.40
		INJECTABLE DRUGS	14,399.16

TOTAL NUMBER OF CLAIMS 1,314

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,620.29	0.00
MED/SURG SUPPLY	34,427.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,362.42	163.80
CT SCAN	458,961.89	24,002.60
PHYSICAL THERAPY	51,029.03	9,815.13
EKG/ECG	54,846.40	195.88
IV THERAPY	272,269.04	4,101.02
OPERATING ROOM	51,566.95	6,022.93
LABOR/DELIVERY ROOM	843.60	0.00
RESPIRATORY SERVICES	39,175.02	9,730.63
ANESTHESIA	19,657.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	838,153.48	4,581.94
RECOVERY ROOM	23,382.24	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,581.08	223.04
SPEECH PATHOLOGY	536.25	2,790.33
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	900.00	1,181.04
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	55,967.97	2,173.48
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,699.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,240.96	222.04
AUDIOLOGY	2,016.35	0.00
CARDIOLOGY	11,517.60	1,884.40
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	63,597.13	6,885.88

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	90,695.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,826.40
OTHER THERAPEUTIC SVC	0.00	374.79
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	507,843.20	28,110.86
MRI SERVICES	35,325.85	4,637.43
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79,221.45	27,156.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	7,239.05
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,855,438.27	143,319.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,855,438.27	143,319.61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,580.64	ADJUSTMENTS	0.00
COVERED CHARGES	24,815.06	CONTRACTUAL ALLOW	19,652.37
NON-COVERD CHARGES	1,765.58	TOTAL MEDICAID LIAB	5,162.69
		LESS: COB	5,162.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.96	0.00	OTHER LAB	1,024.66	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,016.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,329.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,164.86	0.00
EKG/ECG	391.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,854.99	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	281.20	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	245.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,297.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	917.51	6.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	522.34	527.35	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	950.28			

TOTAL ANCILLARY	24,815.06	1,765.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,815.06	1,765.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,719.32	ADJUSTMENTS	78.32
COVERED CHARGES	78,304.74	CONTRACTUAL ALLOW	71,490.90
NON-COVERD CHARGES	1,414.58	TOTAL MEDICAID LIAB	6,813.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,813.84

TOTAL NUMBER OF CLAIMS 87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.70	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,483.96	0.00
CT SCAN	4,263.85	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	391.76	0.00
IV THERAPY	3,816.20	0.00
OPERATING ROOM	0.00	395.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,750.93	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,049.69	522.34
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,024.66	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,519.99	17.81
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,921.00	479.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	78,304.74	1,414.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,304.74	1,414.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,621.15	ADJUSTMENTS	0.00
COVERED CHARGES	3,621.15	CONTRACTUAL ALLOW	3,307.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	313.28
		LESS: COB	313.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	583.46	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	295.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,524.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53.84	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,621.15	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,621.15	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	244,676.84	ADJUSTMENTS	25,164.90
COVERED CHARGES	238,442.03	CONTRACTUAL ALLOW	213,277.13
NON-COVERD CHARGES	6,234.81	TOTAL MEDICAID LIAB	25,164.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,164.90

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,214.67	0.00
MED/SURG SUPPLY	196,170.81	105.26
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	579.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	398.57
EKG/ECG	0.00	0.00
IV THERAPY	1,427.04	0.00
OPERATING ROOM	14,608.48	3,290.42
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	490.20	0.00
ANESTHESIA	9,970.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	8,102.92	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	858.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,580.41	151.74
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,439.00	2,288.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	238,442.03	6,234.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	238,442.03	6,234.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER HABERSHAM LLC
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0037

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	172,338,398.28	ADJUSTMENTS	6,049,729.19
COVERED CHARGES	169,697,097.05	CONTRACTUAL ALLOW	143,022,749.90
NON-COVERD CHARGES	2,641,301.23	TOTAL MEDICAID LIAB	26,674,347.15
		LESS: COB	276,915.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	34,398.00
		REIMBURSEMENT	26,431,830.12

TOTAL NUMBER OF ADMISSIONS 2,610

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9,749	0	18,639,062.00	0.00
ROUTINE NURSERY	2,319	0	5,409,550.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12,068	0	24,048,612.00	0.00
SPECIAL CARE SERVICES				
CCU	116	0	466,172.00	0.00
ICU	2,552	0	8,932,061.00	0.00
NICU	49	0	245,000.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	112	0	661,276.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,829	0	10,304,509.00	0.00
TOTAL ACCOMODATIONS	14,897	0	34,353,121.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,032,295.91	1,254,661.00
MED/SURG SUPPLY	7,876,290.13	146.23
LABORATORY-GENERAL	17,602,252.00	6,264.00
RADIOLOGY-DIAGNOSTIC	1,786,386.00	704.00
CT SCAN	8,017,739.00	5,158.00
PHYSICAL THERAPY	618,835.00	0.00
EKG/ECG	990,364.00	404.00
IV THERAPY	3,122,849.00	1,874.00
OPERATING ROOM	13,173,308.00	8,028.00
LABOR/DELIVERY ROOM	3,214,077.00	0.00
RESPIRATORY SERVICES	5,687,566.00	0.00
ANESTHESIA	5,587,042.00	0.00
GI SERVICES	850,074.00	0.00
EMERGENCY ROOM	4,394,254.00	2,709.00
RECOVERY ROOM	3,590,069.00	0.00
LABORATORY PATHOLOGIC	667,956.00	0.00
RADIOLOGY THERAPEUTIC	422,054.00	0.00
OCCUPATIONAL THERAPY	282,385.00	0.00
SPEECH PATHOLOGY	438,819.00	0.00
RENAL DIALYSIS	1,902,326.00	284,939.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	87,746.00	85,621.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	892,585.00	372,180.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,730,249.00	1,428.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	167,174.00	103,917.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,054,874.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	406,558.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,527,374.00	1,575.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,205,340.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	46,610.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,325,449.00	0.00
PROFESSIONAL FEES	0.00	720.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	510,973.00
IMPL DEV CHARGE PATIENTS	9,635,145.01	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	7,931.00	0.00

TOTAL ANCILLARY	135,343,976.05	2,641,301.23
TOTAL ACCOMODATIONS	34,353,121.00	0.00
TOTAL CHARGES	169,697,097.05	2,641,301.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022342074993	10/02/22 - 10/13/22	12/12/22	1,782.00	0.00	0.00	0.00	0.00
614	2023076086062	02/24/23 - 03/11/23	03/20/23	1,782.00	0.00	0.00	0.00	0.00
614	2323221000220	12/27/22 - 02/06/23	08/14/23	4,367.00	0.00	0.00	33.44	0.00
TOTAL				7,931.00	0.00	0.00	33.44	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,576,665.11	ADJUSTMENTS	0.00
COVERED CHARGES	3,531,435.11	CONTRACTUAL ALLOW	3,000,500.32
NON-COVERD CHARGES	45,230.00	TOTAL MEDICAID LIAB	530,934.79
		LESS: COB	531,753.79
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	819.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	201	0	433,031.00	0.00
ROUTINE NURSERY	174	0	515,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	375	0	948,531.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	8,310.00	0.00
ICU	19	0	64,353.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	21	0	72,663.00	0.00
TOTAL ACCOMODATIONS	396	0	1,021,194.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	459,511.00	6,376.00
MED/SURG SUPPLY	228,922.61	0.00
LABORATORY-GENERAL	261,187.00	0.00
RADIOLOGY-DIAGNOSTIC	13,506.00	0.00
CT SCAN	83,416.00	0.00
PHYSICAL THERAPY	11,283.00	0.00
EKG/ECG	8,484.00	0.00
IV THERAPY	21,080.00	0.00
OPERATING ROOM	285,673.00	0.00
LABOR/DELIVERY ROOM	299,532.00	0.00
RESPIRATORY SERVICES	104,833.00	0.00
ANESTHESIA	188,448.00	0.00
GI SERVICES	3,515.00	0.00
EMERGENCY ROOM	44,583.00	0.00
RECOVERY ROOM	202,187.00	0.00
LABORATORY PATHOLOGIC	17,505.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,197.00	0.00
SPEECH PATHOLOGY	7,508.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,961.00	8,111.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,616.00	10,187.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	40,218.00	18,010.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,629.00	2,546.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	35,441.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,331.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	10,888.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,072.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,031.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	140,683.50	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,510,241.11	45,230.00
TOTAL ACCOMODATIONS	1,021,194.00	0.00
TOTAL CHARGES	3,531,435.11	45,230.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,069,735.91	ADJUSTMENTS	497,661.61
COVERED CHARGES	49,848,650.40	CONTRACTUAL ALLOW	43,976,471.83
NON-COVERD CHARGES	10,221,085.51	TOTAL MEDICAID LIAB	5,872,178.57
		LESS: COB	9,097.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,863,081.19
		ALL OTHER	4,929,207.18
		FEE SCHEDULE-LAB	513,000.21
		INJECTABLE DRUGS	420,873.80

TOTAL NUMBER OF CLAIMS 10,739

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,976.00	1,033,723.00
MED/SURG SUPPLY	767,594.20	871,365.34
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,211,856.00	42,380.00
CT SCAN	4,771,838.00	692,189.00
PHYSICAL THERAPY	318,626.00	55,959.00
EKG/ECG	588,654.00	10,100.00
IV THERAPY	2,885,073.00	48,979.00
OPERATING ROOM	3,317,132.42	971,308.58
LABOR/DELIVERY ROOM	32,619.00	3,924.00
RESPIRATORY SERVICES	410,538.00	30,294.00
ANESTHESIA	2,016,170.00	0.00
GI SERVICES	857,611.27	137,214.73
EMERGENCY ROOM	5,854,067.00	15,240.00
RECOVERY ROOM	2,296,860.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,429,545.00	122,349.00
OCCUPATIONAL THERAPY	89,493.00	57,275.00
SPEECH PATHOLOGY	33,635.00	22,703.00
RENAL DIALYSIS	0.00	435,708.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	41,669.00	423.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,809,474.00	454,033.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	166,564.00	25,785.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	749,097.00	335,319.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,697,349.00	523,060.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	348,465.00	830.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,187,765.85	167,016.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	759,500.00	4,518.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	738.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,397,672.92	820,634.00
MRI SERVICES	1,406,298.00	111,123.00
PROFESSIONAL FEES	0.00	50.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	21,298.00
INJECTABLE DRUGS	3,363,969.00	1,559,580.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	277,633.00
IMPL DEV CHARGE PATIENTS	18,192.74	1,362,491.72
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	5,346.00	5,842.00

TOTAL ANCILLARY	49,848,650.40	10,221,085.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,848,650.40	10,221,085.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022305047096	10/27/22 - 10/27/22	11/07/22	1,782.00	0.00	0.00	0.00	230.07
614	2023114019303	02/02/23 - 02/02/23	05/01/23	1,782.00	0.00	0.00	0.00	230.07
614	2123160000019	05/22/23 - 05/22/23	07/17/23	0.00	1,782.00	0.00	0.00	0.00
614	2023264068219	09/16/23 - 09/16/23	09/25/23	1,782.00	0.00	0.00	0.00	210.33
614	2023268021455	09/19/23 - 09/19/23	10/02/23	0.00	4,060.00	0.00	0.00	0.00
TOTAL				5,346.00	5,842.00	0.00	0.00	670.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,299,191.98	ADJUSTMENTS	0.00
COVERED CHARGES	990,763.64	CONTRACTUAL ALLOW	885,462.63
NON-COVERD CHARGES	308,428.34	TOTAL MEDICAID LIAB	105,301.01
		LESS: COB	105,301.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 197

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.00	29,860.00
MED/SURG SUPPLY	1,777.19	2,492.61
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,265.00	864.00
CT SCAN	58,990.00	77,399.00
PHYSICAL THERAPY	2,055.00	2,434.00
EKG/ECG	18,584.00	0.00
IV THERAPY	92,971.00	3,958.00
OPERATING ROOM	33,807.45	21,444.55
LABOR/DELIVERY ROOM	6,765.00	1,124.00
RESPIRATORY SERVICES	4,311.00	538.00
ANESTHESIA	47,310.00	0.00
GI SERVICES	3,607.00	21,512.00
EMERGENCY ROOM	249,963.00	0.00
RECOVERY ROOM	52,158.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,961.00	0.00
OCCUPATIONAL THERAPY	0.00	5,518.00
SPEECH PATHOLOGY	1,944.00	550.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	760.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	22,391.00	40,853.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,030.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,650.00	10,925.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,856.00	24,408.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,559.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	31,856.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,790.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	205,032.00	26,488.00
MRI SERVICES	10,646.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,443.00	31,919.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,774.18
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	4,367.00

TOTAL ANCILLARY	990,763.64	308,428.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	990,763.64	308,428.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023226016173	07/09/23 - 07/09/23	08/21/23	0.00	4,367.00	0.00	1,210.55	0.00
TOTAL				0.00	4,367.00	0.00	1,210.55	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	281,387.04	ADJUSTMENTS	134.26
COVERED CHARGES	262,406.04	CONTRACTUAL ALLOW	254,551.83
NON-COVERD CHARGES	18,981.00	TOTAL MEDICAID LIAB	7,854.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,854.21

TOTAL NUMBER OF CLAIMS 117

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.00	5,863.00
MED/SURG SUPPLY	5,067.37	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,790.00	0.00
CT SCAN	5,158.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,828.00	0.00
IV THERAPY	30,867.00	0.00
OPERATING ROOM	12,561.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	996.00	0.00
ANESTHESIA	5,460.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	153,201.00	0.00
RECOVERY ROOM	4,267.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,305.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,420.00	3,669.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,471.67	9,449.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	262,406.04	18,981.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	262,406.04	18,981.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,884.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,884.00	CONTRACTUAL ALLOW	3,816.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	67.13
		LESS: COB	67.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,140.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,744.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,884.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,884.00	0.00

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,919,020.11	ADJUSTMENTS	141,497.00
COVERED CHARGES	8,458,092.34	CONTRACTUAL ALLOW	7,620,801.34
NON-COVERD CHARGES	3,460,927.77	TOTAL MEDICAID LIAB	837,291.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	837,291.00

TOTAL NUMBER OF CLAIMS 146

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.00	205,182.00
MED/SURG SUPPLY	814,234.74	559,807.69
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,538.00	46,502.00
CT SCAN	30,138.00	9,176.00
PHYSICAL THERAPY	958.00	10,370.00
EKG/ECG	25,856.00	404.00
IV THERAPY	61,765.00	0.00
OPERATING ROOM	2,499,521.17	335,721.83
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,854.00	0.00
ANESTHESIA	915,905.00	28,610.00
GI SERVICES	80,201.85	21,757.15
EMERGENCY ROOM	27,090.00	0.00
RECOVERY ROOM	774,384.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	627,971.00	53,166.00
OCCUPATIONAL THERAPY	0.00	777.00
SPEECH PATHOLOGY	0.00	3,099.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	23,383.00	1,633.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,655.00	2,640.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	580.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	537,253.00	78,890.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	59,086.00	102,145.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	699.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	200,282.00	34,705.00
MRI SERVICES	0.00	5,260.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,436,205.00	195,624.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	249,983.58	1,764,878.10
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,458,092.34	3,460,927.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,458,092.34	3,460,927.77

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	291,002.38	ADJUSTMENTS	0.00
COVERED CHARGES	242,305.75	CONTRACTUAL ALLOW	225,327.64
NON-COVERD CHARGES	48,696.63	TOTAL MEDICAID LIAB	16,978.11
		LESS: COB	16,978.11
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	6,413.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38,511.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,589.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	692.00	FEE SCHEDULE LAB	3,300.00	39.00
EKG/ECG	404.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,521.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,184.20	7,775.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,076.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,398.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,144.00	7,983.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	326.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,045.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	42,658.55	17,744.83
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,520.00	6,678.00			

TOTAL ANCILLARY	242,305.75	48,696.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	242,305.75	48,696.63

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,343,954.78	ADJUSTMENTS	1,375,082.04
COVERED CHARGES	39,015,035.78	CONTRACTUAL ALLOW	33,067,176.33
NON-COVERD CHARGES	328,919.00	TOTAL MEDICAID LIAB	5,947,859.45
		LESS: COB	62,078.51
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	3,213.00
		REIMBURSEMENT	5,888,993.94

TOTAL NUMBER OF ADMISSIONS 471

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,011	0	3,512,844.00	0.00
ROUTINE NURSERY	262	0	615,300.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,273	0	4,128,144.00	0.00
SPECIAL CARE SERVICES				
CCU	34	0	113,302.00	0.00
ICU	686	0	2,682,511.00	0.00
NICU	5	0	25,000.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	725	0	2,820,813.00	0.00
TOTAL ACCOMODATIONS	2,998	0	6,948,957.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,124,924.00	220,385.00
MED/SURG SUPPLY	1,315,885.12	0.00
LABORATORY-GENERAL	4,390,518.00	0.00
RADIOLOGY-DIAGNOSTIC	465,284.00	0.00
CT SCAN	2,006,562.00	0.00
PHYSICAL THERAPY	224,670.00	0.00
EKG/ECG	209,269.00	0.00
IV THERAPY	976,071.00	0.00
OPERATING ROOM	2,446,070.00	0.00
LABOR/DELIVERY ROOM	141,834.00	0.00
RESPIRATORY SERVICES	1,782,759.00	0.00
ANESTHESIA	898,801.00	0.00
GI SERVICES	178,459.00	0.00
EMERGENCY ROOM	984,287.00	0.00
RECOVERY ROOM	527,492.00	0.00
LABORATORY PATHOLOGIC	248,811.00	0.00
RADIOLOGY THERAPEUTIC	133,944.00	0.00
OCCUPATIONAL THERAPY	149,359.00	0.00
SPEECH PATHOLOGY	116,393.00	0.00
RENAL DIALYSIS	513,813.00	83,863.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,284.00	15,332.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	315,916.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	795,558.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,383.00	9,339.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,356,440.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	57,975.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	660,836.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	240,914.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	417,875.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,328,128.66	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,564.00	0.00

TOTAL ANCILLARY	32,066,078.78	328,919.00
TOTAL ACCOMODATIONS	6,948,957.00	0.00
TOTAL CHARGES	39,015,035.78	328,919.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022334054806	11/02/22 - 11/07/22	12/05/22	1,782.00	0.00	0.00	0.00	0.00
614	2023299065976	09/25/23 - 09/29/23	10/30/23	1,782.00	0.00	0.00	0.00	0.00
TOTAL				3,564.00	0.00	0.00	0.00	0.00

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	527,905.23	ADJUSTMENTS	0.00
COVERED CHARGES	524,574.23	CONTRACTUAL ALLOW	439,976.12
NON-COVERD CHARGES	3,331.00	TOTAL MEDICAID LIAB	84,598.11
		LESS: COB	84,787.11
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	189.00
		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	31	0	69,069.00	0.00
ROUTINE NURSERY	29	0	104,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	173,869.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	8,310.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	8,310.00	0.00
TOTAL ACCOMODATIONS	62	0	182,179.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,545.00	0.00
MED/SURG SUPPLY	21,475.23	0.00
LABORATORY-GENERAL	47,109.00	0.00
RADIOLOGY-DIAGNOSTIC	1,056.00	0.00
CT SCAN	8,093.00	0.00
PHYSICAL THERAPY	1,404.00	0.00
EKG/ECG	2,828.00	0.00
IV THERAPY	15,460.00	0.00
OPERATING ROOM	35,440.00	0.00
LABOR/DELIVERY ROOM	34,268.00	0.00
RESPIRATORY SERVICES	6,171.00	0.00
ANESTHESIA	20,831.00	0.00
GI SERVICES	2,963.00	0.00
EMERGENCY ROOM	10,478.00	0.00
RECOVERY ROOM	34,089.00	0.00
LABORATORY PATHOLOGIC	603.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,749.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	564.00	3,331.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,726.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,068.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,245.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,040.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,190.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	342,395.23	3,331.00
TOTAL ACCOMODATIONS	182,179.00	0.00
TOTAL CHARGES	524,574.23	3,331.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,794,012.07	ADJUSTMENTS	104,303.67
COVERED CHARGES	14,783,991.84	CONTRACTUAL ALLOW	13,028,490.74
NON-COVERD CHARGES	3,010,020.23	TOTAL MEDICAID LIAB	1,755,501.10
		LESS: COB	6,921.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,748,579.77
		ALL OTHER	1,574,171.33
		FEE SCHEDULE-LAB	139,597.39
		INJECTABLE DRUGS	34,811.05

TOTAL NUMBER OF CLAIMS 2,487

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,992.00	258,819.00
MED/SURG SUPPLY	236,675.39	213,096.88
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	441,815.00	7,361.00
CT SCAN	1,949,082.00	204,220.00
PHYSICAL THERAPY	115,907.00	20,469.00
EKG/ECG	223,829.00	4,040.00
IV THERAPY	938,739.00	4,100.00
OPERATING ROOM	1,123,127.34	214,132.66
LABOR/DELIVERY ROOM	12,642.00	664.00
RESPIRATORY SERVICES	74,284.00	5,918.00
ANESTHESIA	579,998.00	0.00
GI SERVICES	208,935.33	72,047.67
EMERGENCY ROOM	2,250,523.78	4,294.00
RECOVERY ROOM	655,364.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	969,780.00	112,783.00
OCCUPATIONAL THERAPY	9,602.00	2,742.00
SPEECH PATHOLOGY	305.00	2,123.00
RENAL DIALYSIS	0.00	54,474.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,476.00	423.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	244,415.00	23,154.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	44,460.00	1,725.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	276,902.00	88,270.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	738,218.00	180,275.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	49,476.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	295,620.00	29,410.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	349,733.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,903,042.50	244,029.00
MRI SERVICES	566,368.00	44,197.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	416,948.00	652,310.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	99,168.50	564,942.42
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,564.00	0.00

TOTAL ANCILLARY	14,783,991.84	3,010,020.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,783,991.84	3,010,020.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022322069833	10/11/22 - 10/11/22	11/21/22	1,782.00	0.00	0.00	0.00	230.07
614	5923118000537	11/22/22 - 11/22/22	05/01/23	1,782.00	0.00	0.00	0.00	230.07
TOTAL				3,564.00	0.00	0.00	0.00	460.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	621,198.67	ADJUSTMENTS	0.00
COVERED CHARGES	470,824.98	CONTRACTUAL ALLOW	416,417.34
NON-COVERD CHARGES	150,373.69	TOTAL MEDICAID LIAB	54,407.64
		LESS: COB	54,407.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.00	14,930.00
MED/SURG SUPPLY	15,876.04	690.53
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,168.00	1,230.00
CT SCAN	47,821.00	54,695.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,696.00	0.00
IV THERAPY	36,160.00	0.00
OPERATING ROOM	0.00	23,904.00
LABOR/DELIVERY ROOM	4,277.00	0.00
RESPIRATORY SERVICES	663.00	0.00
ANESTHESIA	19,993.00	0.00
GI SERVICES	4,251.00	15,811.00
EMERGENCY ROOM	126,873.94	0.00
RECOVERY ROOM	19,470.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	37,505.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	141.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,464.00	2,373.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,629.00	716.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,068.00	4,068.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,195.00	3,339.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,683.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	83,673.00	8,903.00
MRI SERVICES	14,717.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,628.00	8,467.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	11,106.16
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	470,824.98	150,373.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	470,824.98	150,373.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,196.00	ADJUSTMENTS	0.00
COVERED CHARGES	96,214.00	CONTRACTUAL ALLOW	92,723.24
NON-COVERD CHARGES	982.00	TOTAL MEDICAID LIAB	3,490.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,490.76

TOTAL NUMBER OF CLAIMS 52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	170.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,174.00	0.00
CT SCAN	3,190.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	404.00	0.00
IV THERAPY	500.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72,905.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,905.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,784.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,823.00	735.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	529.00	77.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	96,214.00	982.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,214.00	982.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,361.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,321.00	CONTRACTUAL ALLOW	4,186.74
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	134.26
		LESS: COB	134.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	352.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	404.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,744.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	821.00	39.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,321.00	40.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,321.00	40.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,862,988.69	ADJUSTMENTS	17,195.89
COVERED CHARGES	3,403,857.65	CONTRACTUAL ALLOW	3,125,024.06
NON-COVERD CHARGES	1,459,131.04	TOTAL MEDICAID LIAB	278,833.59
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	278,833.59

TOTAL NUMBER OF CLAIMS 49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91.00	88,886.00
MED/SURG SUPPLY	326,363.84	136,453.44
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,475.00	340.00
CT SCAN	19,867.00	2,991.00
PHYSICAL THERAPY	1,450.00	9,541.00
EKG/ECG	12,928.00	0.00
IV THERAPY	70,349.00	0.00
OPERATING ROOM	1,004,663.88	176,220.12
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,424.00	0.00
ANESTHESIA	473,502.00	0.00
GI SERVICES	12,862.40	3,215.60
EMERGENCY ROOM	13,563.00	0.00
RECOVERY ROOM	367,221.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	137,917.00	0.00
OCCUPATIONAL THERAPY	978.00	6,717.00
SPEECH PATHOLOGY	0.00	1,693.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,905.00	926.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,053.00	405.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	580.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	129,683.00	55,695.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	28,244.00	81,916.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,441.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,784.00	5,542.00
MRI SERVICES	0.00	2,554.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44,417.00	82,339.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	666,675.53	803,116.88
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,403,857.65	1,459,131.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,403,857.65	1,459,131.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,471,899.18	ADJUSTMENTS	1,876,458.97
COVERED CHARGES	38,419,304.18	CONTRACTUAL ALLOW	32,074,602.91
NON-COVERD CHARGES	52,595.00	TOTAL MEDICAID LIAB	6,344,701.27
		LESS: COB	61,581.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	16,317.00
		REIMBURSEMENT	6,299,436.58

TOTAL NUMBER OF ADMISSIONS 866

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,175	0	3,881,540.00	0.00
ROUTINE NURSERY	704	0	2,011,445.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,879	0	5,892,985.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	501	0	2,149,652.00	0.00
NICU	6	0	48,456.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	507	0	2,198,108.00	0.00
TOTAL ACCOMODATIONS	3,386	0	8,091,093.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,564,727.34	0.00
MED/SURG SUPPLY	1,760,961.29	2,289.00
LABORATORY-GENERAL	6,099,936.00	0.00
RADIOLOGY-DIAGNOSTIC	565,286.00	0.00
CT SCAN	1,392,029.00	28,611.00
PHYSICAL THERAPY	251,691.00	0.00
EKG/ECG	1,250,163.00	0.00
IV THERAPY	467,509.00	0.00
OPERATING ROOM	3,684,687.00	0.00
LABOR/DELIVERY ROOM	2,122,337.00	604.00
RESPIRATORY SERVICES	2,358,719.00	0.00
ANESTHESIA	305,376.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,147,854.00	0.00
RECOVERY ROOM	235,838.00	0.00
LABORATORY PATHOLOGIC	68,036.00	0.00
RADIOLOGY THERAPEUTIC	175,660.00	0.00
OCCUPATIONAL THERAPY	88,715.00	0.00
SPEECH PATHOLOGY	54,301.00	0.00
RENAL DIALYSIS	270,199.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	44,147.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	164,116.00	0.00
BLOOD	2,135.00	0.00
BLOOD STORAGE & PRO.	203,846.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	197,845.00	1,822.00
AUDIOLOGY	199,052.00	0.00
CARDIOLOGY	1,993,196.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	50,253.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	261,590.00	1,095.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	119,109.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	246,515.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,528.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	18,174.00
IMPL DEV CHARGE PATIENTS	850,928.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	64,926.00	0.00

TOTAL ANCILLARY	30,328,211.18	52,595.00
TOTAL ACCOMODATIONS	8,091,093.00	0.00
TOTAL CHARGES	38,419,304.18	52,595.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022308061398	10/23/22 - 10/28/22	11/07/22	5,955.00	0.00	0.00	0.00	0.00
614	5223022000015	11/22/22 - 12/20/22	01/30/23	4,589.00	0.00	0.00	0.00	0.00
614	2023030014758	01/15/23 - 01/19/23	02/06/23	4,724.00	0.00	0.00	0.00	0.00
614	2023059052334	02/13/23 - 02/21/23	03/06/23	5,955.00	0.00	0.00	0.00	0.00
614	2223096007183	01/10/23 - 03/22/23	04/10/23	4,018.00	0.00	0.00	0.00	0.00
614	2023107021753	04/03/23 - 04/07/23	04/24/23	3,364.00	0.00	0.00	0.00	0.00
614	2023171045554	05/08/23 - 05/10/23	06/26/23	5,360.00	0.00	0.00	0.00	0.00
614	2023207000002	07/05/23 - 07/20/23	07/31/23	3,028.00	0.00	0.00	0.00	0.00
614	5223221000562	07/21/23 - 07/27/23	08/14/23	4,236.00	0.00	0.00	0.00	0.00
614	2323230000134	04/10/23 - 04/15/23	09/18/23	4,589.00	0.00	0.00	0.00	0.00
614	5223332000244	08/02/23 - 08/07/23	12/04/23	5,360.00	0.00	0.00	0.00	0.00
614	5223332000246	08/07/23 - 08/15/23	12/04/23	3,028.00	0.00	0.00	0.00	0.00
614	2024043038802	05/05/23 - 05/11/23	02/19/24	5,360.00	0.00	0.00	0.00	0.00
614	2024043038934	06/29/23 - 07/05/23	02/19/24	5,360.00	0.00	0.00	0.00	0.00
TOTAL				64,926.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	493,286.51	ADJUSTMENTS	0.00
COVERED CHARGES	493,286.51	CONTRACTUAL ALLOW	403,689.28
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	89,597.23
		LESS: COB	90,038.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	441.00
		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	25	0	44,045.00	0.00
ROUTINE NURSERY	35	0	127,682.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	171,727.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	60	0	171,727.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,171.51	0.00	OTHER LAB	2,901.00	0.00
MED/SURG SUPPLY	21,527.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,760.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,773.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,791.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,170.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,089.00	0.00	MRI SERVICES	9,446.00	0.00
IV THERAPY	1,234.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,729.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	67,577.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,777.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,204.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,720.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,846.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,038.00	0.00	INJECTABLE DRUGS	160.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,444.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,914.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,449.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	7,385.00	0.00			
CARDIOLOGY	2,230.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,224.00	0.00			

TOTAL ANCILLARY	321,559.51	0.00
TOTAL ACCOMODATIONS	171,727.00	0.00
TOTAL CHARGES	493,286.51	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,199,487.21	ADJUSTMENTS	935,243.01
COVERED CHARGES	31,703,591.40	CONTRACTUAL ALLOW	27,346,468.30
NON-COVERD CHARGES	1,495,895.81	TOTAL MEDICAID LIAB	4,357,123.10
		LESS: COB	4,728.55
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,352,394.55
		ALL OTHER	3,231,512.01
		FEE SCHEDULE-LAB	393,702.22
		INJECTABLE DRUGS	727,180.32

TOTAL NUMBER OF CLAIMS 7,254

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,274,060.41	3,178.00
MED/SURG SUPPLY	430,293.48	4,983.00
LABORATORY-GENERAL	0.00	167.00
RADIOLOGY-DIAGNOSTIC	984,442.00	11,057.00
CT SCAN	3,095,495.00	143,418.00
PHYSICAL THERAPY	227,645.00	25,371.00
EKG/ECG	590,884.00	2,112.00
IV THERAPY	1,681,465.00	2,884.00
OPERATING ROOM	1,859,329.60	131,991.40
LABOR/DELIVERY ROOM	493.00	0.00
RESPIRATORY SERVICES	193,451.00	8,026.00
ANESTHESIA	315,969.00	0.00
GI SERVICES	8,426.00	0.00
EMERGENCY ROOM	4,630,905.50	3,253.50
RECOVERY ROOM	128,695.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	456,741.00	17,699.00
OCCUPATIONAL THERAPY	50,828.00	13,181.00
SPEECH PATHOLOGY	5,190.00	7,546.00
RENAL DIALYSIS	0.00	52,985.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,212.00	168.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	989,327.00	26,176.00
BLOOD	485.00	0.00
BLOOD STORAGE & PRO.	69,264.00	377.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	634,674.00	2,959.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	691,241.00	14,892.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	161,514.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	961,198.00	18,105.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	961,369.00	100,492.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,452.00	0.00
OTHER THERAPEUTIC SVC	13,399.00	5,185.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,337,184.00	258,764.00
MRI SERVICES	1,001,306.00	26,167.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,784,125.41	584,080.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	30,678.00
IMPL DEV CHARGE PATIENTS	69,943.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	83,585.00	0.00

TOTAL ANCILLARY	31,703,591.40	1,495,895.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,703,591.40	1,495,895.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022283013137	10/04/22 - 10/04/22	10/17/22	4,236.00	0.00	0.00	0.00	641.22
614	2022325031084	11/15/22 - 11/15/22	11/28/22	2,345.00	0.00	0.00	0.00	354.97
614	2022337027327	11/28/22 - 11/28/22	12/12/22	4,370.00	0.00	0.00	0.00	661.50
614	2022353014678	12/14/22 - 12/14/22	12/26/22	4,236.00	0.00	0.00	0.00	641.22
614	2022362026660	12/23/22 - 12/23/22	01/02/23	4,236.00	0.00	0.00	0.00	641.22
614	2223117004130	03/13/23 - 03/13/23	05/01/23	3,717.00	0.00	0.00	0.00	562.66
614	2023135016450	05/09/23 - 05/09/23	05/22/23	4,236.00	0.00	0.00	0.00	641.22
614	5923142000148	04/28/23 - 04/28/23	05/29/23	4,236.00	0.00	0.00	0.00	641.22
614	2023163014526	06/06/23 - 06/06/23	06/19/23	4,236.00	0.00	0.00	0.00	641.22
614	2023177011690	06/21/23 - 06/21/23	07/03/23	2,345.00	0.00	0.00	0.00	354.97
614	2023186043011	06/30/23 - 06/30/23	07/10/23	4,252.00	0.00	0.00	0.00	643.65
614	2223191003943	05/25/23 - 05/25/23	07/17/23	5,360.00	0.00	0.00	0.00	811.36
614	2023191013818	07/05/23 - 07/05/23	07/17/23	3,700.00	0.00	0.00	0.00	560.08
614	2023192036478	07/06/23 - 07/06/23	07/17/23	4,236.00	0.00	0.00	0.00	641.22
614	2023200045384	07/14/23 - 07/14/23	07/24/23	4,090.00	0.00	0.00	0.00	619.12
614	2023222024106	08/04/23 - 08/04/23	08/14/23	4,236.00	0.00	0.00	0.00	641.22
614	2023228041773	08/11/23 - 08/11/23	08/21/23	4,236.00	0.00	0.00	0.00	641.22
614	2023240015007	08/23/23 - 08/23/23	09/04/23	3,682.00	0.00	0.00	0.00	557.35
614	2023256041947	09/08/23 - 09/08/23	09/18/23	3,682.00	0.00	0.00	0.00	528.11
614	2023261014602	09/11/23 - 09/11/23	09/25/23	4,236.00	0.00	0.00	0.00	607.58
614	5923296000132	09/28/23 - 09/28/23	10/30/23	3,682.00	0.00	0.00	0.00	528.11
TOTAL				83,585.00	0.00	0.00	0.00	12,560.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	892,691.16	ADJUSTMENTS	0.00
COVERED CHARGES	719,107.40	CONTRACTUAL ALLOW	627,515.21
NON-COVERD CHARGES	173,583.76	TOTAL MEDICAID LIAB	91,592.19
		LESS: COB	91,592.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 137

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,782.72	6,912.00
MED/SURG SUPPLY	11,161.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,587.00	729.00
CT SCAN	93,794.00	47,905.00
PHYSICAL THERAPY	919.00	2,627.00
EKG/ECG	21,009.00	501.00
IV THERAPY	54,541.00	2,429.00
OPERATING ROOM	18,594.50	13,088.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,302.00	407.00
ANESTHESIA	3,610.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	151,743.00	0.00
RECOVERY ROOM	2,204.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	665.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	168.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,767.00	5,674.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,156.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	24,906.00	74.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,805.00	9,834.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,702.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	33,506.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	35,723.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,515.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	149,627.00	6,139.00
MRI SERVICES	7,581.00	30,317.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,224.18	41,767.26
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	695.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	719,107.40	173,583.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	719,107.40	173,583.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	271,061.98	ADJUSTMENTS	604.17
COVERED CHARGES	265,836.33	CONTRACTUAL ALLOW	258,921.94
NON-COVERD CHARGES	5,225.65	TOTAL MEDICAID LIAB	6,914.39
		LESS: COB	62.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,852.18

TOTAL NUMBER OF CLAIMS 103

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,669.12	0.00	OTHER LAB	1,739.00	0.00
MED/SURG SUPPLY	1,036.00	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,962.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,562.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,745.00	3,657.00
EKG/ECG	7,230.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,266.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,343.00	1,343.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,854.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,059.21	41.65
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	5,051.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	320.00	0.00			

TOTAL ANCILLARY	265,836.33	5,225.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	265,836.33	5,225.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,787.99	ADJUSTMENTS	0.00
COVERED CHARGES	29,840.59	CONTRACTUAL ALLOW	29,504.94
NON-COVERD CHARGES	6,947.40	TOTAL MEDICAID LIAB	335.65
		LESS: COB	335.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,690.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	383.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,124.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,482.00	6,681.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,097.00	248.00
EKG/ECG	501.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,889.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,674.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	18.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,840.59	6,947.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,840.59	6,947.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,759,662.48	ADJUSTMENTS	421,575.22
COVERED CHARGES	10,221,474.01	CONTRACTUAL ALLOW	9,255,360.32
NON-COVERD CHARGES	538,188.47	TOTAL MEDICAID LIAB	966,113.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	966,113.69

TOTAL NUMBER OF CLAIMS 179

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	171,555.10	279.00
MED/SURG SUPPLY	227,825.00	41.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,939.00	183,114.00
CT SCAN	96,007.00	11,276.00
PHYSICAL THERAPY	0.00	6,205.00
EKG/ECG	21,474.00	0.00
IV THERAPY	262,941.00	1,601.00
OPERATING ROOM	1,427,558.00	126,913.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,152.00	1,655.00
ANESTHESIA	48,128.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,949.00	0.00
RECOVERY ROOM	32,149.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	636,749.00	0.00
OCCUPATIONAL THERAPY	0.00	4,374.00
SPEECH PATHOLOGY	0.00	5,063.00
RENAL DIALYSIS	0.00	8,905.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,775.00	14,671.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	35,896.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,840.00	7,168.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	440,986.00	4,596.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	64,350.00	1,435.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,526.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,632.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	298,573.00	7,315.00
MRI SERVICES	10,082.00	3,415.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,079,507.91	141,527.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	7,003.00
IMPL DEV CHARGE PATIENTS	1,229,512.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,221,474.01	538,188.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,221,474.01	538,188.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	171,197.95	ADJUSTMENTS	0.00
COVERED CHARGES	168,658.81	CONTRACTUAL ALLOW	157,875.87
NON-COVERD CHARGES	2,539.14	TOTAL MEDICAID LIAB	10,782.94
		LESS: COB	10,782.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,285.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,906.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	614.00	FEE SCHEDULE LAB	1,915.00	64.00
EKG/ECG	501.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,313.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,595.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,042.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	1,861.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122,856.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	168,658.81	2,539.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,658.81	2,539.14

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	355,212,103.93	ADJUSTMENTS	46,160,666.00
COVERED CHARGES	354,105,043.93	CONTRACTUAL ALLOW	266,226,285.51
NON-COVERD CHARGES	1,107,060.00	TOTAL MEDICAID LIAB	87,878,758.42
		LESS: COB	271,479.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	87,607,278.97

TOTAL NUMBER OF ADMISSIONS 2,321

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13,817	0	41,562,826.50	0.00
ROUTINE NURSERY	1,951	0	14,817,768.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15,768	0	56,380,595.00	0.00
SPECIAL CARE SERVICES				
CCU	1,656	0	19,477,449.00	0.00
ICU	0	0	0.00	0.00
NICU	538	0	5,844,306.00	0.00
PED ICU	3,210	0	27,690,153.50	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,404	0	53,011,908.50	0.00
TOTAL ACCOMODATIONS	21,172	0	109,392,503.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,805,411.50	22,199.00
MED/SURG SUPPLY	5,527,244.82	0.00
LABORATORY-GENERAL	28,299,356.95	2,152.00
RADIOLOGY-DIAGNOSTIC	4,582,686.50	0.00
CT SCAN	2,913,500.00	0.00
PHYSICAL THERAPY	1,682,133.00	0.00
EKG/ECG	465,556.50	0.00
IV THERAPY	1,325,262.50	0.00
OPERATING ROOM	39,373,716.00	2,314.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31,376,886.35	0.00
ANESTHESIA	9,522,242.00	0.00
GI SERVICES	11,291.50	0.00
EMERGENCY ROOM	4,196,792.43	0.00
RECOVERY ROOM	973,020.00	0.00
LABORATORY PATHOLOGIC	1,987,044.50	0.00
RADIOLOGY THERAPEUTIC	325,514.00	0.00
OCCUPATIONAL THERAPY	1,155,359.50	0.00
SPEECH PATHOLOGY	830,888.00	0.00
RENAL DIALYSIS	91,224.00	201,959.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	693.00	37,734.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,184,903.50	94,624.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,730,459.58	10,851.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	73,570.00	170,130.00
AUDIOLOGY	41,838.00	0.00
CARDIOLOGY	8,372,612.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,343,353.50	0.00
ORGAN ACQUISITION	2,949,578.00	58,360.00
TREATMENT/OBSERV. RM	1,843,557.50	342,596.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	954,811.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	101,680.50	76,815.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,477,890.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,791.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	72,917.00
IMPL DEV CHARGE PATIENTS	8,180,672.30	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	14,407.00

TOTAL ANCILLARY	244,712,540.43	1,107,060.00
TOTAL ACCOMODATIONS	109,392,503.50	0.00
TOTAL CHARGES	354,105,043.93	1,107,060.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
873	2023128033179	04/17/23 - 05/04/23	05/15/23	0.00	7,203.50	0.00	0.00	0.00
873	2023242062346	08/10/23 - 08/18/23	09/04/23	0.00	7,203.50	0.00	0.00	0.00
TOTAL				0.00	14,407.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,548,187.76	ADJUSTMENTS	0.00
COVERED CHARGES	17,518,822.76	CONTRACTUAL ALLOW	15,453,107.11
NON-COVERD CHARGES	29,365.00	TOTAL MEDICAID LIAB	2,065,715.65
		LESS: COB	2,065,715.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 87

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	378	0	1,086,774.00	0.00
ROUTINE NURSERY	133	0	1,158,324.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	511	0	2,245,098.50	0.00
SPECIAL CARE SERVICES				
CCU	232	0	2,716,408.00	0.00
ICU	0	0	0.00	0.00
NICU	14	0	150,318.00	0.00
PED ICU	93	0	651,061.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	339	0	3,517,787.00	0.00
TOTAL ACCOMODATIONS	850	0	5,762,885.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,826,727.75	0.00
MED/SURG SUPPLY	353,990.74	0.00
LABORATORY-GENERAL	1,125,567.77	0.00
RADIOLOGY-DIAGNOSTIC	225,282.50	0.00
CT SCAN	72,497.00	0.00
PHYSICAL THERAPY	52,039.00	0.00
EKG/ECG	12,563.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,450,270.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,710,458.68	0.00
ANESTHESIA	615,806.00	0.00
GI SERVICES	1,026.50	0.00
EMERGENCY ROOM	184,032.00	0.00
RECOVERY ROOM	40,591.50	0.00
LABORATORY PATHOLOGIC	51,889.00	0.00
RADIOLOGY THERAPEUTIC	1,755.00	0.00
OCCUPATIONAL THERAPY	49,582.50	0.00
SPEECH PATHOLOGY	36,181.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	147.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	66,025.50	10,783.50
BLOOD	0.00	2,806.00
BLOOD STORAGE & PRO.	147,765.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,487.50	168.00
AUDIOLOGY	6,499.50	0.00
CARDIOLOGY	701,198.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	482,501.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	95,476.50	11,907.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	48,046.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	2,749.50	3,700.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	50,984.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,684.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	338,111.32	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,755,937.26	29,365.00
TOTAL ACCOMODATIONS	5,762,885.50	0.00
TOTAL CHARGES	17,518,822.76	29,365.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,752,494.98	ADJUSTMENTS	993,808.75
COVERED CHARGES	86,176,068.71	CONTRACTUAL ALLOW	67,988,464.69
NON-COVERD CHARGES	11,576,426.27	TOTAL MEDICAID LIAB	18,187,604.02
		LESS: COB	19,798.35
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	18,167,805.67
		ALL OTHER	12,719,618.91
		FEE SCHEDULE-LAB	776,847.36
		INJECTABLE DRUGS	4,671,339.40

TOTAL NUMBER OF CLAIMS 13,216

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,880,191.75	6,671.00
MED/SURG SUPPLY	1,785,223.43	1,917.43
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,565,244.00	33,971.00
CT SCAN	1,754,051.00	92,220.00
PHYSICAL THERAPY	21,940.00	30,366.50
EKG/ECG	185,098.00	37,129.00
IV THERAPY	2,332,012.50	195,178.00
OPERATING ROOM	11,436,994.60	905,411.90
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	766,502.78	99,496.00
ANESTHESIA	5,034,527.00	20,441.00
GI SERVICES	1,026.50	2,114.50
EMERGENCY ROOM	8,720,450.50	74,249.00
RECOVERY ROOM	1,734,911.50	5,765.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	307,951.00	20,034.50
OCCUPATIONAL THERAPY	6,650.50	5,451.00
SPEECH PATHOLOGY	356,420.50	25,978.00
RENAL DIALYSIS	0.00	10,057.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,586,262.00	58,503.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	874,286.50	138,275.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,146,222.00	91,096.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	483,765.00	42,006.00
AUDIOLOGY	83,109.50	15,436.00
CARDIOLOGY	2,468,353.51	832,054.99
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,195,085.00	15,472.00
ORGAN ACQUISITION	0.00	30,726.00
TREATMENT/OBSERV. RM	3,417,185.64	1,078,921.76

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	386,731.00	5,032.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,225.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,371,018.37	4,927,671.67
MRI SERVICES	3,888,504.00	369,265.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,890,724.62	2,237,785.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	86,991.50
IMPL DEV CHARGE PATIENTS	495,626.01	16,399.06
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	60,112.50

TOTAL ANCILLARY	86,176,068.71	11,576,426.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,176,068.71	11,576,426.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
872	2223055004173	02/07/23 - 02/07/23	02/27/23	0.00	9,360.00	0.00	0.00	0.00
871	2023097088416	03/21/23 - 03/21/23	04/17/23	0.00	7,557.50	0.00	0.00	0.00
872	2023097088416	03/21/23 - 03/21/23	04/17/23	0.00	9,360.00	0.00	0.00	0.00
872	2023194082190	07/05/23 - 07/05/23	07/17/23	0.00	9,360.00	0.00	0.00	0.00
871	2023326068963	10/31/23 - 10/31/23	11/27/23	0.00	7,557.50	0.00	0.00	0.00
871	2023326068963	10/31/23 - 10/31/23	11/27/23	0.00	7,557.50	0.00	0.00	0.00
872	2023326068963	10/31/23 - 10/31/23	11/27/23	0.00	9,360.00	0.00	0.00	0.00
TOTAL				0.00	60,112.50	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,308,878.37	ADJUSTMENTS	0.00
COVERED CHARGES	5,046,822.60	CONTRACTUAL ALLOW	4,013,877.17
NON-COVERD CHARGES	1,262,055.77	TOTAL MEDICAID LIAB	1,032,945.43
		LESS: COB	1,032,945.43
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 832

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,123.50	0.00
MED/SURG SUPPLY	85,044.07	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	111,776.00	11,664.00
CT SCAN	142,094.00	122,767.50
PHYSICAL THERAPY	0.00	507.00
EKG/ECG	11,452.50	1,393.50
IV THERAPY	28,451.00	4,942.00
OPERATING ROOM	1,048,033.99	127,182.51
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,692.00	2,433.00
ANESTHESIA	560,409.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	492,580.50	5,062.50
RECOVERY ROOM	185,011.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	91,944.00	10,966.50
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	20,804.00	14,032.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	69,040.00	4,023.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	49,048.50	14,820.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41,788.50	2,701.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	65,521.00	3,606.00
AUDIOLOGY	6,639.50	1,102.00
CARDIOLOGY	86,342.00	92,725.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	43,542.00	22,129.50
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	177,305.50	20,803.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	21,318.00	1,895.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	746,186.24	146,141.76
MRI SERVICES	270,659.00	89,991.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	520,144.00	559,422.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	1,743.50
IMPL DEV CHARGE PATIENTS	28,871.80	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,046,822.60	1,262,055.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,046,822.60	1,262,055.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,103,025.37	ADJUSTMENTS	134.26
COVERED CHARGES	1,076,053.62	CONTRACTUAL ALLOW	1,047,587.15
NON-COVERD CHARGES	26,971.75	TOTAL MEDICAID LIAB	28,466.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	28,466.47

TOTAL NUMBER OF CLAIMS 425

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,672.75	0.00
MED/SURG SUPPLY	10,659.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,918.00	9,760.00
CT SCAN	16,634.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,393.50	0.00
IV THERAPY	20,354.50	789.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,200.00	297.50
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	792,359.50	1,722.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	207.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,264.00	3,049.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	275.00	413.50
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,297.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	123,451.82	3,416.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,573.25	7,316.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,076,053.62	26,971.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,076,053.62	26,971.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,446.77	ADJUSTMENTS	0.00
COVERED CHARGES	85,357.52	CONTRACTUAL ALLOW	83,209.36
NON-COVERD CHARGES	2,089.25	TOTAL MEDICAID LIAB	2,148.16
		LESS: COB	2,148.16
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,834.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,284.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,812.50	225.50
EKG/ECG	1,233.50	464.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,510.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.25	100.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,361.00	1,299.00			

TOTAL ANCILLARY	85,357.52	2,089.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	85,357.52	2,089.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,762,998.82	ADJUSTMENTS	72,354.14
COVERED CHARGES	36,362,259.08	CONTRACTUAL ALLOW	32,665,927.36
NON-COVERD CHARGES	3,400,739.74	TOTAL MEDICAID LIAB	3,696,331.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,696,331.72

TOTAL NUMBER OF CLAIMS 356

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137,060.00	103.25
MED/SURG SUPPLY	1,887,832.91	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,243.00	78,532.50
CT SCAN	2,284.00	4,471.50
PHYSICAL THERAPY	692.50	3,841.00
EKG/ECG	5,398.50	6,967.50
IV THERAPY	370,212.00	75,048.00
OPERATING ROOM	2,859,750.98	123,342.01
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	63,270.53	6,532.00
ANESTHESIA	1,965,377.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,064.50	4,137.00
RECOVERY ROOM	170,216.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	22,044.00	1,981.50
OCCUPATIONAL THERAPY	692.50	564.00
SPEECH PATHOLOGY	0.00	2,144.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,210.50	94.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,514.50	12,300.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,273.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,256.00	58,700.50
AUDIOLOGY	0.00	550.00
CARDIOLOGY	2,255,424.37	2,341,730.64
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,323.50	1,970.50
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	377,565.01	65,282.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,188.50	7,116.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	543,512.64	233,913.65
MRI SERVICES	29,742.50	3,439.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,108,746.70	362,590.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	3,468.50
IMPL DEV CHARGE PATIENTS	2,396,362.44	1,919.64
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	36,362,259.08	3,400,739.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,362,259.08	3,400,739.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	607,961.22	ADJUSTMENTS	0.00
COVERED CHARGES	379,402.37	CONTRACTUAL ALLOW	326,341.41
NON-COVERD CHARGES	228,558.85	TOTAL MEDICAID LIAB	53,060.96
		LESS: COB	53,060.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARTHUR M BLANK HOSPITAL INC
2220 N DRUID HILLS RD NE
ATLANTA,GA 30329-3117

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	890.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	114,537.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	422.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	692.50	FEE SCHEDULE LAB	1,650.60	0.10
EKG/ECG	464.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,697.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,714.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,744.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,633.00	2,781.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,709.99	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,711.50	225,084.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,227.00	0.00			

TOTAL ANCILLARY	379,402.37	228,558.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	379,402.37	228,558.85

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	331,723.12	ADJUSTMENTS	0.00
COVERED CHARGES	331,723.12	CONTRACTUAL ALLOW	241,471.28
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	90,251.84
		LESS: COB	710.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	89,541.31

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	64,081.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	39	0	64,081.00	0.00
SPECIAL CARE SERVICES				
CCU	20	0	49,369.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	20	0	49,369.00	0.00
TOTAL ACCOMODATIONS	59	0	113,450.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,736.05	0.00	OTHER LAB	1,410.00	0.00
MED/SURG SUPPLY	11,001.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,001.00	0.00	EDUCATION & TRAINING	187.00	0.00
RADIOLOGY-DIAGNOSTIC	7,609.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,123.07	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,769.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,211.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,409.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,890.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,662.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,530.00	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/OBSERV. RM	333.00	0.00			

TOTAL ANCILLARY	218,273.12	0.00
TOTAL ACCOMODATIONS	113,450.00	0.00
TOTAL CHARGES	331,723.12	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,300,193.47	ADJUSTMENTS	59,948.47
COVERED CHARGES	3,950,028.31	CONTRACTUAL ALLOW	3,116,907.27
NON-COVERD CHARGES	350,165.16	TOTAL MEDICAID LIAB	833,121.04
		LESS: COB	1,821.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	831,299.74
		ALL OTHER	767,306.55
		FEE SCHEDULE-LAB	53,793.86
		INJECTABLE DRUGS	10,199.33

TOTAL NUMBER OF CLAIMS 1,584

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,316.08	25,321.47
MED/SURG SUPPLY	12,691.44	2,021.59
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	215,403.00	32,647.00
CT SCAN	1,025,773.08	77,420.17
PHYSICAL THERAPY	142,768.00	38,150.00
EKG/ECG	55,404.00	3,240.00
IV THERAPY	335,802.00	44,524.00
OPERATING ROOM	157,442.50	3,727.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46,749.00	7,589.00
ANESTHESIA	25,172.00	0.00
GI SERVICES	66,171.32	1,341.68
EMERGENCY ROOM	1,013,267.00	4,339.00
RECOVERY ROOM	11,609.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	437.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	80,478.00	4,436.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,831.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,226.00	4,530.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	39,776.00	246.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,325.00	1,299.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	112.00
OTHER THERAPEUTIC SVC	3,462.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	503,979.00	41,324.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	154,032.89	51,422.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	350.00	6,037.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,950,028.31	350,165.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,950,028.31	350,165.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	73,951.44	ADJUSTMENTS	0.00
COVERED CHARGES	60,705.17	CONTRACTUAL ALLOW	47,734.69
NON-COVERD CHARGES	13,246.27	TOTAL MEDICAID LIAB	12,970.48
		LESS: COB	12,970.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126.05	579.92
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,004.00	331.00
CT SCAN	6,848.02	8,366.02
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	648.00	0.00
IV THERAPY	8,668.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,200.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	2,713.00	0.00
EMERGENCY ROOM	22,127.00	2,579.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,616.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,469.00	545.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,286.10	845.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	60,705.17	13,246.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,705.17	13,246.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	417,746.62	ADJUSTMENTS	210.00
COVERED CHARGES	408,749.59	CONTRACTUAL ALLOW	394,609.59
NON-COVERD CHARGES	8,997.03	TOTAL MEDICAID LIAB	14,140.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	14,140.00

TOTAL NUMBER OF CLAIMS 202

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	415.52	975.00	OTHER LAB	2,591.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,238.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,270.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,252.00	2,027.00
EKG/ECG	5,832.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,614.00	3,351.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,800.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,040.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,363.91	2,555.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	89.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	333.00	0.00			

TOTAL ANCILLARY	408,749.59	8,997.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	408,749.59	8,997.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,220.08	ADJUSTMENTS	0.00
COVERED CHARGES	5,220.08	CONTRACTUAL ALLOW	4,940.08
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	280.00
		LESS: COB	280.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	496.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	281.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	336.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,971.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	136.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,220.08	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,220.08	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	90,631.56	ADJUSTMENTS	0.00
COVERED CHARGES	73,373.32	CONTRACTUAL ALLOW	61,225.56
NON-COVERD CHARGES	17,258.24	TOTAL MEDICAID LIAB	12,147.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,147.76

TOTAL NUMBER OF CLAIMS 2

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	470.21	1,029.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	371.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,068.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,602.75	9,569.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,868.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	753.11	2,771.07
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,888.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,373.32	17,258.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,373.32	17,258.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,980,129.34	ADJUSTMENTS	298,037.15
COVERED CHARGES	19,958,048.18	CONTRACTUAL ALLOW	14,805,809.13
NON-COVERD CHARGES	22,081.16	TOTAL MEDICAID LIAB	5,152,239.05
		LESS: COB	50,672.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	7,938.00
		REIMBURSEMENT	5,109,504.31

TOTAL NUMBER OF ADMISSIONS 769

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,808	0	4,838,014.00	0.00
ROUTINE NURSERY	330	0	486,700.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,138	0	5,324,714.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	449	0	1,310,615.00	0.00
NICU	17	0	70,575.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	466	0	1,381,190.00	0.00
TOTAL ACCOMODATIONS	3,604	0	6,705,904.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	776,157.25	0.00
MED/SURG SUPPLY	472,000.42	238.00
LABORATORY-GENERAL	1,355,401.04	0.00
RADIOLOGY-DIAGNOSTIC	331,805.00	0.00
CT SCAN	489,055.00	1,583.00
PHYSICAL THERAPY	312,018.59	0.00
EKG/ECG	242,572.00	0.00
IV THERAPY	26,479.04	0.00
OPERATING ROOM	1,610,839.00	2,232.00
LABOR/DELIVERY ROOM	663,234.00	0.00
RESPIRATORY SERVICES	1,436,849.08	0.00
ANESTHESIA	190,340.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,482,522.44	0.00
RECOVERY ROOM	110,575.00	0.00
LABORATORY PATHOLOGIC	136,317.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	52,185.42	0.00
SPEECH PATHOLOGY	63,310.38	0.00
RENAL DIALYSIS	146,194.70	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,376.98	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	79,876.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	79,114.00	18,028.16
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	40,343.92	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,004,050.17	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,823.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	304,660.57	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	65,862.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	92,782.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	368,739.68	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	281,660.02	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	2,000.00	0.00

TOTAL ANCILLARY	13,252,144.18	22,081.16
TOTAL ACCOMODATIONS	6,705,904.00	0.00
TOTAL CHARGES	19,958,048.18	22,081.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2223166010415	05/23/23 - 05/24/23	06/19/23	1,000.00	0.00	0.00	0.00	0.00
615	2024011060082	12/22/23 - 12/25/23	01/15/24	1,000.00	0.00	0.00	0.00	0.00
TOTAL				2,000.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	345,180.64	ADJUSTMENTS	0.00
COVERED CHARGES	345,062.64	CONTRACTUAL ALLOW	248,086.90
NON-COVERD CHARGES	118.00	TOTAL MEDICAID LIAB	96,975.74
		LESS: COB	97,164.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	189.00
		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	48	0	81,894.00	0.00
ROUTINE NURSERY	7	0	9,675.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	55	0	91,569.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	10	0	21,350.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	10	0	21,350.00	0.00
TOTAL ACCOMODATIONS	65	0	112,919.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,758.94	0.00	OTHER LAB	859.00	0.00
MED/SURG SUPPLY	5,004.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	56,531.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,781.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,645.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,381.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,490.00	0.00	MRI SERVICES	2,265.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	118.00
OPERATING ROOM	27,227.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,652.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,593.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,073.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,460.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,987.00	0.00	INJECTABLE DRUGS	3,582.37	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	812.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,595.92	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	75.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	569.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,324.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,235.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,640.00	0.00			

TOTAL ANCILLARY	232,143.64	118.00
TOTAL ACCOMODATIONS	112,919.00	0.00
TOTAL CHARGES	345,062.64	118.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,439,904.10	ADJUSTMENTS	606,398.36
COVERED CHARGES	14,263,646.91	CONTRACTUAL ALLOW	11,350,036.15
NON-COVERD CHARGES	1,176,257.19	TOTAL MEDICAID LIAB	2,913,610.76
		LESS: COB	22,581.66
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,891,029.10
		ALL OTHER	2,564,132.69
		FEE SCHEDULE-LAB	265,749.20
		INJECTABLE DRUGS	61,147.21

TOTAL NUMBER OF CLAIMS 5,869

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,998.60	8,444.62
MED/SURG SUPPLY	94,596.76	23,425.81
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	655,361.72	7,277.64
CT SCAN	858,155.00	66,235.00
PHYSICAL THERAPY	209,208.00	56,405.00
EKG/ECG	295,294.00	1,490.00
IV THERAPY	1,273,860.69	4,838.54
OPERATING ROOM	1,066,589.92	292,358.12
LABOR/DELIVERY ROOM	24,044.00	222.00
RESPIRATORY SERVICES	146,375.42	27,907.85
ANESTHESIA	165,450.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,544,586.72	14,008.00
RECOVERY ROOM	197,204.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	32,310.95	87.00
OCCUPATIONAL THERAPY	67,198.88	12,916.86
SPEECH PATHOLOGY	9,999.01	10,370.24
RENAL DIALYSIS	0.00	16,253.88
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	461,591.49	88,713.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	318,990.22	25,781.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,675.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	47,354.84	4,413.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	311,736.41	130,854.07
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,477.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	366,226.33	724.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	289,120.00	407.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	254.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,323,206.40	85,741.92
MRI SERVICES	83,957.00	4,000.00
PROFESSIONAL FEES	0.00	4,577.56
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	627.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	319,900.41	229,055.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	13,297.14	59,750.01
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,263,646.91	1,176,257.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,263,646.91	1,176,257.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	378,476.95	ADJUSTMENTS	0.00
COVERED CHARGES	255,065.13	CONTRACTUAL ALLOW	203,486.75
NON-COVERD CHARGES	123,411.82	TOTAL MEDICAID LIAB	51,578.38
		LESS: COB	51,578.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 114

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	730.99	73.65
MED/SURG SUPPLY	7,551.30	1,388.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,955.56	2,928.00
CT SCAN	2,000.00	6,225.00
PHYSICAL THERAPY	4,008.00	2,376.00
EKG/ECG	4,172.00	0.00
IV THERAPY	9,983.97	0.00
OPERATING ROOM	25,855.00	86,481.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	844.37	0.00
ANESTHESIA	18,570.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	112,226.13	2,935.00
RECOVERY ROOM	10,080.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	335.86
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,442.00	985.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,792.00	2,020.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,416.56	167.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,233.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,881.00	684.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,035.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,015.88	2,150.16
MRI SERVICES	1,415.00	2,537.00
PROFESSIONAL FEES	0.00	436.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,857.37	5,852.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	5,838.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	255,065.13	123,411.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	255,065.13	123,411.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	331,592.28	ADJUSTMENTS	67.13
COVERED CHARGES	330,292.00	CONTRACTUAL ALLOW	320,692.41
NON-COVERD CHARGES	1,300.28	TOTAL MEDICAID LIAB	9,599.59
		LESS: COB	0.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,598.99

TOTAL NUMBER OF CLAIMS 143

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.25	0.00
MED/SURG SUPPLY	81.12	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,510.84	0.00
CT SCAN	11,045.00	800.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,980.00	0.00
IV THERAPY	10,908.95	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	527.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	278,543.32	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,616.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	814.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,308.52	468.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	839.00	32.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	330,292.00	1,300.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	330,292.00	1,300.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,452.54	ADJUSTMENTS	0.00
COVERED CHARGES	60,275.31	CONTRACTUAL ALLOW	58,597.06
NON-COVERD CHARGES	4,177.23	TOTAL MEDICAID LIAB	1,678.25
		LESS: COB	1,678.25
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76.65	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,651.64	0.00
CT SCAN	800.00	2,400.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	596.00	0.00
IV THERAPY	1,838.41	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,982.41	1,311.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	404.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,718.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,580.40	48.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31.80	14.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	60,275.31	4,177.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,275.31	4,177.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,753,775.16	ADJUSTMENTS	62,073.65
COVERED CHARGES	1,504,602.16	CONTRACTUAL ALLOW	1,323,522.26
NON-COVERD CHARGES	249,173.00	TOTAL MEDICAID LIAB	181,079.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	181,079.90

TOTAL NUMBER OF CLAIMS 35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	638.33	326.74
MED/SURG SUPPLY	124,744.37	56,323.28
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,518.20	10,692.00
CT SCAN	4,150.00	945.00
PHYSICAL THERAPY	0.00	8,021.00
EKG/ECG	2,980.00	1,490.00
IV THERAPY	68,233.27	0.00
OPERATING ROOM	476,979.00	73,230.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	527.00	0.00
ANESTHESIA	65,870.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,300.00	0.00
RECOVERY ROOM	55,965.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,836.31	0.00
OCCUPATIONAL THERAPY	0.00	4,013.86
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	7,950.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	92,529.09	17,500.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,730.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,356.12	360.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	487,213.22	29,813.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	40,032.25	38,507.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,504,602.16	249,173.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,504,602.16	249,173.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,950.53	ADJUSTMENTS	0.00
COVERED CHARGES	10,157.18	CONTRACTUAL ALLOW	5,077.95
NON-COVERD CHARGES	793.35	TOTAL MEDICAID LIAB	5,079.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,063.00
		REIMBURSEMENT	6,142.23

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	850.00	0.00
ROUTINE NURSERY	2	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	3	0	2,290.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	2,290.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	661.30	0.00
MED/SURG SUPPLY	636.80	0.00
LABORATORY-GENERAL	766.25	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	876.26	0.00
LABOR/DELIVERY ROOM	4,633.42	0.00
RESPIRATORY SERVICES	68.75	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	793.35
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	224.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,867.18	793.35
TOTAL ACCOMODATIONS	2,290.00	0.00
TOTAL CHARGES	10,157.18	793.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,870.07	ADJUSTMENTS	0.00
COVERED CHARGES	119,372.87	CONTRACTUAL ALLOW	92,856.59
NON-COVERD CHARGES	30,497.20	TOTAL MEDICAID LIAB	26,516.28
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	26,516.28
		ALL OTHER	22,865.96
		FEE SCHEDULE-LAB	3,645.48
		INJECTABLE DRUGS	4.84

TOTAL NUMBER OF CLAIMS 73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,148.10	1,052.30
MED/SURG SUPPLY	1,819.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,013.11	323.60
CT SCAN	4,980.50	26,295.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,781.50	0.00
IV THERAPY	3,327.00	0.00
OPERATING ROOM	32,675.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,925.00	671.70
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,354.85	0.00
RECOVERY ROOM	2,127.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,558.25	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	3,679.28	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	743.64	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,221.24	1,929.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18.90	225.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	119,372.87	30,497.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,372.87	30,497.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,811.21	ADJUSTMENTS	0.00
COVERED CHARGES	17,630.16	CONTRACTUAL ALLOW	16,690.32
NON-COVERD CHARGES	4,181.05	TOTAL MEDICAID LIAB	939.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	939.84

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.95	194.30
MED/SURG SUPPLY	267.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	970.80	0.00
CT SCAN	0.00	3,540.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	532.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	825.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,170.30	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,301.37	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,226.24	441.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.50	4.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,630.16	4,181.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,630.16	4,181.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 01/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,029.24	ADJUSTMENTS	0.00
COVERED CHARGES	6,029.24	CONTRACTUAL ALLOW	-1,250.41
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,279.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,279.65

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	824.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	824.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	824.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,044.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	185.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	917.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	353.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,467.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	237.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,205.24	0.00
TOTAL ACCOMODATIONS	824.00	0.00
TOTAL CHARGES	6,029.24	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	246,294.81	ADJUSTMENTS	2,191.60
COVERED CHARGES	218,317.69	CONTRACTUAL ALLOW	114,081.68
NON-COVERD CHARGES	27,977.12	TOTAL MEDICAID LIAB	104,236.01
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	104,236.01
		ALL OTHER	87,801.78
		FEE SCHEDULE-LAB	15,881.41
		INJECTABLE DRUGS	552.82

TOTAL NUMBER OF CLAIMS 383

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697.55	815.40
MED/SURG SUPPLY	2,636.20	252.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,519.30	1,510.70
CT SCAN	29,237.90	16,713.70
PHYSICAL THERAPY	9,425.60	2,140.00
EKG/ECG	1,412.50	0.00
IV THERAPY	695.40	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	144.00	48.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	40,419.20	271.40
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	7,132.00	708.80
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,902.30	466.90
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	1,644.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,540.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	97,321.10	1,835.10
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,589.94	3,214.72
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	218,317.69	27,977.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	218,317.69	27,977.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,099.27	ADJUSTMENTS	70.00
COVERED CHARGES	19,314.37	CONTRACTUAL ALLOW	16,584.37
NON-COVERD CHARGES	3,784.90	TOTAL MEDICAID LIAB	2,730.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,730.00

TOTAL NUMBER OF CLAIMS 39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152.00	0.00
MED/SURG SUPPLY	248.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	859.50	192.00
CT SCAN	2,525.70	3,549.90
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,974.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,420.30	41.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,134.87	2.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,314.37	3,784.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,314.37	3,784.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,944,650.69	ADJUSTMENTS	5,702.25
COVERED CHARGES	1,938,688.85	CONTRACTUAL ALLOW	1,434,138.36
NON-COVERD CHARGES	5,961.84	TOTAL MEDICAID LIAB	504,550.49
		LESS: COB	276.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	504,274.19

TOTAL NUMBER OF ADMISSIONS 90

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	505	0	651,936.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	505	0	651,936.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	22	0	26,400.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	22	0	26,400.00	0.00
TOTAL ACCOMODATIONS	527	0	678,336.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	538,300.00	0.00
MED/SURG SUPPLY	99,257.20	0.00
LABORATORY-GENERAL	300,691.21	0.00
RADIOLOGY-DIAGNOSTIC	15,754.54	0.00
CT SCAN	94,417.00	0.00
PHYSICAL THERAPY	871.28	0.00
EKG/ECG	10,783.32	0.00
IV THERAPY	16,499.60	0.00
OPERATING ROOM	7,020.00	3,510.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	103,851.92	0.00
ANESTHESIA	1,275.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	40,039.78	0.00
RECOVERY ROOM	1,620.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,687.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,032.00	462.72
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,842.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,883.00	1,989.12

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,498.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,260,352.85	5,961.84
TOTAL ACCOMODATIONS	678,336.00	0.00
TOTAL CHARGES	1,938,688.85	5,961.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,620,162.39	ADJUSTMENTS	15,078.97
COVERED CHARGES	3,056,404.28	CONTRACTUAL ALLOW	2,349,553.76
NON-COVERD CHARGES	563,758.11	TOTAL MEDICAID LIAB	706,850.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	706,850.52
		ALL OTHER	632,997.71
		FEE SCHEDULE-LAB	55,867.78
		INJECTABLE DRUGS	17,985.03

TOTAL NUMBER OF CLAIMS 1,385

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,234.90	24,542.00
MED/SURG SUPPLY	138,608.87	469.67
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,878.17	9,852.21
CT SCAN	586,455.00	47,251.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	25,436.16	1,105.92
IV THERAPY	123,353.84	195.00
OPERATING ROOM	61,426.48	12,827.98
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	486,157.16	77,380.00
ANESTHESIA	3,600.00	0.00
GI SERVICES	3,407.00	0.00
EMERGENCY ROOM	214,697.86	1,243.20
RECOVERY ROOM	4,860.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	77,003.28	1,473.76
PSYCHIATRIC SERVICES	230,808.00	2,093.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	46,527.00	11,087.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,217.92	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,421.00	2,807.00
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/OBSERV. RM	55,059.58	13,268.08

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,414.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	577,180.16	27,651.95
MRI SERVICES	67,544.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	182,793.50	330,510.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,400.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	20,920.00	0.00

TOTAL ANCILLARY	3,056,404.28	563,758.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,056,404.28	563,758.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022307074914	10/28/22 - 10/28/22	11/07/22	3,190.00	0.00	0.00	0.00	842.16
614	2023030023894	01/13/23 - 01/13/23	02/06/23	5,910.00	0.00	0.00	0.00	1,560.24
614	2023151045311	05/15/23 - 05/15/23	06/05/23	5,910.00	0.00	0.00	0.00	1,560.24
614	2023261030442	09/11/23 - 09/11/23	09/25/23	5,910.00	0.00	0.00	0.00	2,056.09
TOTAL				20,920.00	0.00	0.00	0.00	6,018.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,896.92	ADJUSTMENTS	0.00
COVERED CHARGES	6,243.92	CONTRACTUAL ALLOW	4,950.09
NON-COVERD CHARGES	7,653.00	TOTAL MEDICAID LIAB	1,293.83
		LESS: COB	1,293.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	134.00
MED/SURG SUPPLY	360.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	6,392.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	120.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,521.24	407.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,674.68	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	568.00	720.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,243.92	7,653.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,243.92	7,653.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	217,005.38	ADJUSTMENTS	0.00
COVERED CHARGES	188,720.73	CONTRACTUAL ALLOW	182,065.97
NON-COVERD CHARGES	28,284.65	TOTAL MEDICAID LIAB	6,654.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,654.76

TOTAL NUMBER OF CLAIMS 96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	780.00	1,894.00
MED/SURG SUPPLY	6,384.79	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,338.80	2,637.64
CT SCAN	83,784.00	18,266.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,073.60	0.00
IV THERAPY	5,608.12	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	968.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,079.28	218.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,941.44	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	796.64	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,579.06	2,528.01
MRI SERVICES	652.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,735.00	2,741.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	188,720.73	28,284.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	188,720.73	28,284.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,117.31	ADJUSTMENTS	0.00
COVERED CHARGES	44,028.36	CONTRACTUAL ALLOW	33,141.52
NON-COVERD CHARGES	1,088.95	TOTAL MEDICAID LIAB	10,886.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	10,886.84

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	728.00
MED/SURG SUPPLY	857.48	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95.00	0.00
CT SCAN	8,136.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	276.48	0.00
IV THERAPY	2,673.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	834.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,683.40	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,416.08	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,494.92	220.95
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	970.00	140.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	20,592.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	44,028.36	1,088.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,028.36	1,088.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	459,373.47	ADJUSTMENTS	0.00
COVERED CHARGES	411,548.97	CONTRACTUAL ALLOW	185,672.10
NON-COVERD CHARGES	47,824.50	TOTAL MEDICAID LIAB	225,876.87
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	225,876.87

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	298	0	239,356.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	298	0	239,356.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	298	0	239,356.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,382.00	43,026.00
MED/SURG SUPPLY	17,464.50	0.00
LABORATORY-GENERAL	22,343.50	0.00
RADIOLOGY-DIAGNOSTIC	6,541.00	0.00
CT SCAN	2,577.78	2,433.00
PHYSICAL THERAPY	1,092.16	0.00
EKG/ECG	5,627.84	0.00
IV THERAPY	29,915.46	0.00
OPERATING ROOM	0.00	1,968.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,376.96	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,473.90	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,283.50	0.00
BLOOD	997.00	0.00
BLOOD STORAGE & PRO.	997.00	397.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,449.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,040.37	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	472.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	99.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	60.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	172,192.97	47,824.50
TOTAL ACCOMODATIONS	239,356.00	0.00
TOTAL CHARGES	411,548.97	47,824.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	736,476.72	ADJUSTMENTS	33,928.34
COVERED CHARGES	653,778.14	CONTRACTUAL ALLOW	402,297.77
NON-COVERD CHARGES	82,698.58	TOTAL MEDICAID LIAB	251,480.37
		LESS: COB	419.98
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	251,060.39
		ALL OTHER	226,651.43
		FEE SCHEDULE-LAB	23,859.31
		INJECTABLE DRUGS	549.65

TOTAL NUMBER OF CLAIMS 723

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,524.00	8,804.00
MED/SURG SUPPLY	10,107.70	24.03
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,181.12	4,582.50
CT SCAN	10,424.82	21,844.60
PHYSICAL THERAPY	73,463.28	6,389.75
EKG/ECG	9,535.68	839.36
IV THERAPY	14,924.72	1,078.48
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,419.00	653.00
ANESTHESIA	1,216.00	0.00
GI SERVICES	6,965.00	0.00
EMERGENCY ROOM	263,563.18	12,308.60
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	13,626.78	6,794.32
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	281.00	131.00
PSYCHIATRIC SERVICES	37,585.05	229.26
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	46,435.54	3,942.18
BLOOD	4,446.62	0.00
BLOOD STORAGE & PRO.	5,648.37	1,191.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,989.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,381.62	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,497.80	174.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	33.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,479.86	10,696.00
MRI SERVICES	2,136.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,935.00	994.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	653,778.14	82,698.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	653,778.14	82,698.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,114.45	ADJUSTMENTS	234.96
COVERED CHARGES	44,529.45	CONTRACTUAL ALLOW	40,186.85
NON-COVERD CHARGES	2,585.00	TOTAL MEDICAID LIAB	4,342.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,342.60

TOTAL NUMBER OF CLAIMS 56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84.00	529.00
MED/SURG SUPPLY	189.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,729.53	169.00
CT SCAN	3,159.00	1,559.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	344.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,215.92	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,515.00	328.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	293.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	44,529.45	2,585.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,529.45	2,585.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	285,092.49	ADJUSTMENTS	0.00
COVERED CHARGES	285,092.49	CONTRACTUAL ALLOW	206,022.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	79,070.37
		LESS: COB	747.43
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	78,322.94

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	212	0	212,000.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	212	0	212,000.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	212	0	212,000.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,249.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,550.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,649.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,539.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,413.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	452.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,214.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,021.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,092.49	0.00
TOTAL ACCOMODATIONS	212,000.00	0.00
TOTAL CHARGES	285,092.49	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,164,676.08	ADJUSTMENTS	56,093.11
COVERED CHARGES	1,079,820.83	CONTRACTUAL ALLOW	794,887.90
NON-COVERD CHARGES	84,855.25	TOTAL MEDICAID LIAB	284,932.93
		LESS: COB	267.61
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	284,665.32
		ALL OTHER	267,340.00
		FEE SCHEDULE-LAB	17,179.37
		INJECTABLE DRUGS	145.95

TOTAL NUMBER OF CLAIMS 567

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,332.55	6,477.30
MED/SURG SUPPLY	1,506.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,684.90	860.00
CT SCAN	119,652.22	10,515.00
PHYSICAL THERAPY	37,217.50	5,007.50
EKG/ECG	9,106.00	0.00
IV THERAPY	357,364.89	1,200.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	55,491.50	34,561.26
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	262,898.64	640.51
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	200.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,567.43	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	824.85	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,718.00	1,859.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	59,267.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,826.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	2,320.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,471.77	1,210.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	690.00	4,100.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	16,104.18

TOTAL ANCILLARY	1,079,820.83	84,855.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,079,820.83	84,855.25

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
948	2023340069926	11/03/23 - 11/03/23	12/11/23	0.00	427.77	0.00	0.00	0.00
948	2023340069926	11/03/23 - 11/03/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/03/23 - 11/03/23	12/11/23	0.00	302.76	0.00	0.00	0.00
948	2023340069926	11/07/23 - 11/07/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/07/23 - 11/07/23	12/11/23	0.00	302.76	0.00	0.00	0.00
948	2023340069926	11/10/23 - 11/10/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/13/23 - 11/13/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/17/23 - 11/17/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/17/23 - 11/17/23	12/11/23	0.00	378.45	0.00	0.00	0.00
948	2023340069926	11/20/23 - 11/20/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/29/23 - 11/29/23	12/11/23	0.00	427.77	0.00	0.00	0.00
948	2023340069926	11/29/23 - 11/29/23	12/11/23	0.00	829.68	0.00	0.00	0.00
948	2023340069926	11/29/23 - 11/29/23	12/11/23	0.00	302.76	0.00	0.00	0.00
948	2024005019318	12/06/23 - 12/06/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/06/23 - 12/06/23	01/08/24	0.00	378.45	0.00	0.00	0.00
948	2024005019318	12/08/23 - 12/08/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/08/23 - 12/08/23	01/08/24	0.00	302.76	0.00	0.00	0.00
948	2024005019318	12/13/23 - 12/13/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/13/23 - 12/13/23	01/08/24	0.00	378.45	0.00	0.00	0.00
948	2024005019318	12/15/23 - 12/15/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/15/23 - 12/15/23	01/08/24	0.00	378.45	0.00	0.00	0.00
948	2024005019318	12/20/23 - 12/20/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/20/23 - 12/20/23	01/08/24	0.00	302.76	0.00	0.00	0.00
948	2024005019318	12/22/23 - 12/22/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/22/23 - 12/22/23	01/08/24	0.00	302.76	0.00	0.00	0.00
948	2024005019318	12/27/23 - 12/27/23	01/08/24	0.00	829.68	0.00	0.00	0.00
948	2024005019318	12/27/23 - 12/27/23	01/08/24	0.00	302.76	0.00	0.00	0.00
TOTAL				0.00	16,104.18	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,168.35	ADJUSTMENTS	0.00
COVERED CHARGES	8,499.15	CONTRACTUAL ALLOW	5,776.49
NON-COVERD CHARGES	3,669.20	TOTAL MEDICAID LIAB	2,722.66
		LESS: COB	2,722.66
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215.00	278.70
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	412.50	0.00
CT SCAN	0.00	2,285.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	5,133.65	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,900.00	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	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,021.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	561.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	277.00	9.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	75.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,499.15	3,669.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,499.15	3,669.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	152,581.23	ADJUSTMENTS	210.00
COVERED CHARGES	150,671.83	CONTRACTUAL ALLOW	144,021.83
NON-COVERD CHARGES	1,909.40	TOTAL MEDICAID LIAB	6,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,650.00

TOTAL NUMBER OF CLAIMS 95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,676.05	1,578.90
MED/SURG SUPPLY	3.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,549.40	0.00
CT SCAN	25,027.06	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,041.00	0.00
IV THERAPY	8,238.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	452.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	91,214.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,376.32	330.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	95.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	150,671.83	1,909.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	150,671.83	1,909.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,920.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,870.00	CONTRACTUAL ALLOW	2,730.00
NON-COVERD CHARGES	50.00	TOTAL MEDICAID LIAB	140.00
		LESS: COB	140.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	50.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	430.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	340.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,100.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,870.00	50.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,870.00	50.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,398.35	ADJUSTMENTS	0.00
COVERED CHARGES	19,365.85	CONTRACTUAL ALLOW	14,207.97
NON-COVERD CHARGES	32.50	TOTAL MEDICAID LIAB	5,157.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,157.88

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,207.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	878.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	866.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	869.50	32.50
EKG/ECG	471.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,279.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	452.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,662.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,680.00	0.00			

TOTAL ANCILLARY	19,365.85	32.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,365.85	32.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF JENKINS COUNTY
931 EAST WINTHROPE AVE.
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,938,874.00	ADJUSTMENTS	705,711.98
COVERED CHARGES	26,768,132.00	CONTRACTUAL ALLOW	22,510,859.84
NON-COVERD CHARGES	170,742.00	TOTAL MEDICAID LIAB	4,257,272.16
		LESS: COB	93,561.83
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,163,710.33

TOTAL NUMBER OF ADMISSIONS 402

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,889	0	3,238,148.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,889	0	3,238,148.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	614	0	3,234,302.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	614	0	3,234,302.00	0.00
TOTAL ACCOMODATIONS	2,503	0	6,472,450.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,809,373.45	21,617.00
MED/SURG SUPPLY	330,156.00	632.00
LABORATORY-GENERAL	4,211,949.00	0.00
RADIOLOGY-DIAGNOSTIC	428,290.00	0.00
CT SCAN	1,983,238.00	3,900.00
PHYSICAL THERAPY	225,736.00	0.00
EKG/ECG	206,081.00	0.00
IV THERAPY	18,975.00	0.00
OPERATING ROOM	1,294,689.00	5,182.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	942,207.00	6,985.00
ANESTHESIA	241,189.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,608,756.00	0.00
RECOVERY ROOM	108,930.00	0.00
LABORATORY PATHOLOGIC	369,477.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	132,399.00	0.00
SPEECH PATHOLOGY	72,876.00	0.00
RENAL DIALYSIS	233,636.00	76,880.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	258.00
PSYCHIATRIC SERVICES	3,366.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	134,894.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	462,667.00	23,010.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	158,143.00	21,672.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	488,052.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	26,737.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	71,071.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	124,458.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	518,445.00	9,454.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	1,152.00
INJECTABLE DRUGS	2,440,766.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	649,125.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,295,682.00	170,742.00
TOTAL ACCOMODATIONS	6,472,450.00	0.00
TOTAL CHARGES	26,768,132.00	170,742.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,412,552.56	ADJUSTMENTS	475,515.38
COVERED CHARGES	10,571,051.72	CONTRACTUAL ALLOW	9,145,815.83
NON-COVERD CHARGES	841,500.84	TOTAL MEDICAID LIAB	1,425,235.89
		LESS: COB	3,970.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,421,265.76
		ALL OTHER	1,274,644.04
		FEE SCHEDULE-LAB	136,647.13
		INJECTABLE DRUGS	9,974.59

TOTAL NUMBER OF CLAIMS 1,500

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	473,966.50	10,070.00
MED/SURG SUPPLY	91,761.00	3,514.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	402,339.00	1,719.00
CT SCAN	1,597,837.00	200,853.00
PHYSICAL THERAPY	0.00	6,316.00
EKG/ECG	179,967.00	0.00
IV THERAPY	501,495.00	8,827.00
OPERATING ROOM	718,701.66	160,965.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	53,901.00	13,457.00
ANESTHESIA	187,193.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,588,622.00	6,202.00
RECOVERY ROOM	152,910.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,180.00
SPEECH PATHOLOGY	0.00	4,240.00
RENAL DIALYSIS	0.00	131,732.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,165.00	311.00
PSYCHIATRIC SERVICES	1,683.00	8,979.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	300,385.00	38,134.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	58,839.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	120,649.00	12,003.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	98,208.00	7,273.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,190.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	236,956.56	6,096.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	85,885.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,842,022.00	60,131.00
MRI SERVICES	483,876.00	54,968.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	269,296.00	77,206.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	117,204.00	24,324.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,571,051.72	841,500.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,571,051.72	841,500.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	389,648.50	ADJUSTMENTS	0.00
COVERED CHARGES	223,036.50	CONTRACTUAL ALLOW	193,836.31
NON-COVERD CHARGES	166,612.00	TOTAL MEDICAID LIAB	29,200.19
		LESS: COB	29,200.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,334.00	0.00
MED/SURG SUPPLY	2,475.00	0.00
LABORATORY-GENERAL	0.00	47.00
RADIOLOGY-DIAGNOSTIC	9,574.00	0.00
CT SCAN	3,900.00	47,301.00
PHYSICAL THERAPY	0.00	865.00
EKG/ECG	3,276.00	0.00
IV THERAPY	20,526.00	765.00
OPERATING ROOM	6,509.00	45,001.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	7,728.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	74,298.00	0.00
RECOVERY ROOM	8,103.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	129.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	9,044.00	7,654.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,436.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,471.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,919.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,688.00	3,125.00
MRI SERVICES	0.00	5,373.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,626.50	3,238.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	53,243.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	223,036.50	166,612.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	223,036.50	166,612.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	331,094.50	ADJUSTMENTS	604.17
COVERED CHARGES	318,192.50	CONTRACTUAL ALLOW	313,157.75
NON-COVERD CHARGES	12,902.00	TOTAL MEDICAID LIAB	5,034.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,034.75

TOTAL NUMBER OF CLAIMS 75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,090.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,362.00	0.00
CT SCAN	36,228.00	6,894.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,148.00	0.00
IV THERAPY	22,463.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	152,040.00	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	1,122.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,487.00	2,470.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,863.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,182.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63,122.00	1,587.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,207.00	829.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	318,192.50	12,902.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	318,192.50	12,902.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,250.50	ADJUSTMENTS	0.00
COVERED CHARGES	31,666.50	CONTRACTUAL ALLOW	31,196.59
NON-COVERD CHARGES	1,584.00	TOTAL MEDICAID LIAB	469.91
		LESS: COB	469.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	475.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,340.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,493.00	274.00
EKG/ECG	936.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,562.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	189.00	75.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	561.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,235.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,761.00	0.00			

TOTAL ANCILLARY	31,666.50	1,584.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,666.50	1,584.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,490,008.96	ADJUSTMENTS	47,592.46
COVERED CHARGES	2,328,449.46	CONTRACTUAL ALLOW	2,143,141.95
NON-COVERD CHARGES	161,559.50	TOTAL MEDICAID LIAB	185,307.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	185,307.51

TOTAL NUMBER OF CLAIMS 31

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,024.00	0.00
MED/SURG SUPPLY	97,095.00	3,052.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,216.00	560.00
CT SCAN	8,258.00	9,593.00
PHYSICAL THERAPY	0.00	14,596.00
EKG/ECG	6,084.00	0.00
IV THERAPY	5,873.00	0.00
OPERATING ROOM	835,546.00	17.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,905.00	0.00
ANESTHESIA	157,240.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,179.00	0.00
RECOVERY ROOM	122,489.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	618.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,728.00	1,235.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,300.00	2,301.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,308.96	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	50,308.00	850.00
MRI SERVICES	19,818.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	29,450.50	44,056.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	901,627.00	84,681.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,328,449.46	161,559.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,328,449.46	161,559.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,512,957.18	ADJUSTMENTS	205,785.66
COVERED CHARGES	11,178,021.11	CONTRACTUAL ALLOW	8,503,264.30
NON-COVERD CHARGES	334,936.07	TOTAL MEDICAID LIAB	2,674,756.81
		LESS: COB	18,966.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	55,977.00
		REIMBURSEMENT	2,711,767.33

TOTAL NUMBER OF ADMISSIONS 379

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,028	0	1,510,689.21	0.00
ROUTINE NURSERY	124	0	157,759.70	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,152	0	1,668,448.91	0.00
SPECIAL CARE SERVICES				
CCU	35	0	73,961.72	0.00
ICU	99	0	288,124.38	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	134	0	362,086.10	0.00
TOTAL ACCOMODATIONS	1,286	0	2,030,535.01	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	399,404.88	0.00
MED/SURG SUPPLY	409,073.10	16.00
LABORATORY-GENERAL	1,485,801.97	3,970.47
RADIOLOGY-DIAGNOSTIC	202,638.73	427.68
CT SCAN	736,456.43	267,146.04
PHYSICAL THERAPY	112,702.98	0.00
EKG/ECG	113,711.06	408.56
IV THERAPY	48,970.96	0.00
OPERATING ROOM	1,121,420.99	2,792.20
LABOR/DELIVERY ROOM	258,927.96	0.00
RESPIRATORY SERVICES	684,098.25	0.00
ANESTHESIA	230,228.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	855,248.22	0.00
RECOVERY ROOM	111,930.33	0.00
LABORATORY PATHOLOGIC	13,899.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	18,792.06	0.00
SPEECH PATHOLOGY	25,970.69	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,751.74	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	50,929.32	10,068.24
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,593.68	35,576.47
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	72,063.29	14,183.78
AUDIOLOGY	0.00	0.00
CARDIOLOGY	666,913.06	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	42,290.82	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	90,725.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	130,225.44	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,109,514.91	89.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	124,202.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	257.40

TOTAL ANCILLARY	9,147,486.10	334,936.07
TOTAL ACCOMODATIONS	2,030,535.01	0.00
TOTAL CHARGES	11,178,021.11	334,936.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022119075053	04/14/22 - 04/16/22	05/09/22	0.00	85.80	0.00	0.00	0.00
780	2022152069558	05/01/22 - 05/09/22	06/06/22	0.00	171.60	0.00	0.00	0.00
TOTAL				0.00	257.40	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,978.80	ADJUSTMENTS	0.00
COVERED CHARGES	3,978.80	CONTRACTUAL ALLOW	2,188.23
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,790.57
		LESS: COB	1,853.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	2	0	2,931.68	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	2,931.68	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	2,931.68	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	898.74	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10.89	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,047.12	0.00
TOTAL ACCOMODATIONS	2,931.68	0.00
TOTAL CHARGES	3,978.80	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,925,953.70	ADJUSTMENTS	195,321.96
COVERED CHARGES	11,106,966.74	CONTRACTUAL ALLOW	9,071,667.81
NON-COVERD CHARGES	818,986.96	TOTAL MEDICAID LIAB	2,035,298.93
		LESS: COB	1,789.79
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,033,509.14
		ALL OTHER	1,927,067.00
		FEE SCHEDULE-LAB	106,441.17
		INJECTABLE DRUGS	0.97

TOTAL NUMBER OF CLAIMS 3,505

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,313.92	0.00
MED/SURG SUPPLY	107,763.77	4,978.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	552,429.91	3,717.05
CT SCAN	2,257,216.10	189,419.61
PHYSICAL THERAPY	62,784.65	11,801.25
EKG/ECG	156,396.96	2,085.70
IV THERAPY	386,261.95	0.00
OPERATING ROOM	953,159.51	164,748.05
LABOR/DELIVERY ROOM	1,097.39	0.00
RESPIRATORY SERVICES	59,111.25	40,568.88
ANESTHESIA	183,131.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,478,160.53	0.00
RECOVERY ROOM	60,469.76	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	138,321.96	33,994.78
OCCUPATIONAL THERAPY	19,675.99	4,910.79
SPEECH PATHOLOGY	1,208.76	3,848.28
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	74,358.12	2,716.94
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	252,187.32	13,375.59
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	47,817.30	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	226,920.72	96,912.59
AUDIOLOGY	712.80	0.00
CARDIOLOGY	421,874.36	57,289.08
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	149,700.70	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	277,863.07	17,906.34

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	86,706.86	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,665,164.49	85,467.80
MRI SERVICES	402,491.67	30,128.10
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4.44	127.49
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	9,176.64
IMPL DEV CHARGE PATIENTS	28,052.00	45,814.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	609.18	0.00

TOTAL ANCILLARY	11,106,966.74	818,986.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,106,966.74	818,986.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022104082937	04/08/22 - 04/08/22	04/18/22	85.80	0.00	0.00	0.00	20.52
780	2022122058648	04/10/22 - 04/10/22	05/09/22	85.80	0.00	0.00	0.00	20.52
780	2022136044942	05/07/22 - 05/07/22	05/23/22	85.80	0.00	0.00	0.00	20.52
780	2022136044942	05/08/22 - 05/08/22	05/23/22	85.80	0.00	0.00	0.00	20.52
780	2022144025140	05/15/22 - 05/15/22	05/30/22	85.80	0.00	0.00	0.00	20.52
780	2022159074675	05/30/22 - 05/30/22	06/13/22	85.80	0.00	0.00	0.00	20.52
780	2023058044192	02/17/23 - 02/17/23	03/06/23	94.38	0.00	0.00	0.00	20.52
TOTAL				609.18	0.00	0.00	0.00	143.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	60,808.06	ADJUSTMENTS	0.00
COVERED CHARGES	35,766.11	CONTRACTUAL ALLOW	30,155.66
NON-COVERD CHARGES	25,041.95	TOTAL MEDICAID LIAB	5,610.45
		LESS: COB	5,610.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.93	0.00
MED/SURG SUPPLY	962.94	2,962.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,370.52	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	189.22	0.00
EKG/ECG	860.02	0.00
IV THERAPY	1,692.31	0.00
OPERATING ROOM	3,255.38	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,908.45	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	378.43
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	818.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,802.02	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	19,754.46
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,361.97	401.76
MRI SERVICES	6,034.78	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	198.47	1,545.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,766.11	25,041.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,766.11	25,041.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,074,445.98	ADJUSTMENTS	0.00
COVERED CHARGES	997,177.21	CONTRACTUAL ALLOW	970,235.13
NON-COVERD CHARGES	77,268.77	TOTAL MEDICAID LIAB	26,942.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	26,942.08

TOTAL NUMBER OF CLAIMS 344

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,251.80	0.00
MED/SURG SUPPLY	3,635.49	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,242.51	0.00
CT SCAN	248,832.85	69,385.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,922.76	0.00
IV THERAPY	57,889.03	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	363.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	429,338.56	906.07
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,689.74	1,048.28
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,716.23	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	164,295.24	5,929.42
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	997,177.21	77,268.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	997,177.21	77,268.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,315.59	ADJUSTMENTS	0.00
COVERED CHARGES	6,277.84	CONTRACTUAL ALLOW	6,121.20
NON-COVERD CHARGES	7,037.75	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	7,037.75
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	451.46	0.00
IV THERAPY	1,070.82	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,089.91	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,639.03	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,277.84	7,037.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,277.84	7,037.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,981,238.02	ADJUSTMENTS	5,391.47
COVERED CHARGES	1,481,322.02	CONTRACTUAL ALLOW	1,324,969.39
NON-COVERD CHARGES	499,916.00	TOTAL MEDICAID LIAB	156,352.63
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	156,352.63

TOTAL NUMBER OF CLAIMS 29

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,090.18	0.00
MED/SURG SUPPLY	92,155.88	15,741.51
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,581.79	0.00
CT SCAN	19,420.90	4,434.14
PHYSICAL THERAPY	0.00	679.87
EKG/ECG	2,988.62	0.00
IV THERAPY	13,303.15	0.00
OPERATING ROOM	534,079.73	314,698.72
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	115,337.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,391.04	0.00
RECOVERY ROOM	38,973.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	95,157.63	0.00
OTHER IMAGING SERVICE	0.00	1,312.14
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,273.84	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	8,501.10
AUDIOLOGY	0.00	0.00
CARDIOLOGY	348,754.66	10,471.66
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,720.33	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,338.07	2,980.54
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	4,588.32
IMPL DEV CHARGE PATIENTS	161,755.00	136,508.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,481,322.02	499,916.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,481,322.02	499,916.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,809.49	ADJUSTMENTS	0.00
COVERED CHARGES	28,133.95	CONTRACTUAL ALLOW	22,742.48
NON-COVERD CHARGES	12,675.54	TOTAL MEDICAID LIAB	5,391.47
		LESS: COB	5,391.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

VIDALIA HEALTH SERVICES, LLC
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 03/01/22 THROUGH 02/28/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,357.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	751.49	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,027.68	12,027.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,537.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	270.22	647.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,133.95	12,675.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,133.95	12,675.54

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	55,838,954.00	ADJUSTMENTS	2,175,973.13
COVERED CHARGES	55,504,687.50	CONTRACTUAL ALLOW	47,695,540.00
NON-COVERD CHARGES	334,266.50	TOTAL MEDICAID LIAB	7,809,147.50
		LESS: COB	78,482.05
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,730,665.45

TOTAL NUMBER OF ADMISSIONS 1,001

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,270	0	6,501,826.00	0.00
ROUTINE NURSERY	1,069	0	2,943,689.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,339	0	9,445,515.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	655	0	3,602,342.00	0.00
NICU	39	0	337,965.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	694	0	3,940,307.00	0.00
TOTAL ACCOMODATIONS	5,033	0	13,385,822.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,651,662.75	17,067.50
MED/SURG SUPPLY	655,241.00	1,756.00
LABORATORY-GENERAL	9,092,295.00	0.00
RADIOLOGY-DIAGNOSTIC	550,859.00	0.00
CT SCAN	2,461,514.00	15,152.00
PHYSICAL THERAPY	610,011.00	0.00
EKG/ECG	299,704.00	0.00
IV THERAPY	36,629.00	0.00
OPERATING ROOM	3,577,002.00	6,911.00
LABOR/DELIVERY ROOM	1,601,932.00	4,463.00
RESPIRATORY SERVICES	1,485,085.00	0.00
ANESTHESIA	636,030.00	0.00
GI SERVICES	50,235.00	0.00
EMERGENCY ROOM	1,744,616.00	0.00
RECOVERY ROOM	474,557.00	0.00
LABORATORY PATHOLOGIC	642,481.00	0.00
RADIOLOGY THERAPEUTIC	545,599.00	0.00
OCCUPATIONAL THERAPY	503,806.00	0.00
SPEECH PATHOLOGY	139,530.00	0.00
RENAL DIALYSIS	305,412.00	34,180.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	129.00	2,580.00
PSYCHIATRIC SERVICES	1,683.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	325,211.00	119,808.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	672,845.00	6,903.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	206,478.00	39,085.00
AUDIOLOGY	147,904.00	0.00
CARDIOLOGY	1,242,383.00	3,837.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	103,418.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,237.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	226,665.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,600.00	0.00
OTHER THERAPEUTIC SVC	0.00	9,966.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,094,647.00	26,498.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	2,374.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	14,310.00
DRUG-SPECIFIC/HOME IV	0.00	29,376.00
INJECTABLE DRUGS	5,132,865.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,871,599.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	42,118,865.50	334,266.50
TOTAL ACCOMODATIONS	13,385,822.00	0.00
TOTAL CHARGES	55,504,687.50	334,266.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,298,996.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,271,969.00	CONTRACTUAL ALLOW	1,152,327.20
NON-COVERD CHARGES	27,027.00	TOTAL MEDICAID LIAB	119,641.80
		LESS: COB	119,641.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	49	0	88,856.00	0.00
ROUTINE NURSERY	84	0	441,655.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	133	0	530,511.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	16	0	83,296.00	0.00
NICU	1	0	8,593.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	91,889.00	0.00
TOTAL ACCOMODATIONS	150	0	622,400.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,849.00	0.00	OTHER LAB	3,049.00	0.00
MED/SURG SUPPLY	20,145.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	155,544.00	0.00	EDUCATION & TRAINING	106.00	0.00
RADIOLOGY-DIAGNOSTIC	9,959.00	0.00	OTHER THERAPEUTIC SVC	0.00	23,097.00
CT SCAN	29,765.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,513.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,808.00	0.00	MRI SERVICES	17,352.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,487.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,046.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,792.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,658.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,565.00	0.00	SPECIAL SERVICES	0.00	3,600.00
RECOVERY ROOM	12,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,780.00	0.00	INJECTABLE DRUGS	60,273.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,871.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,019.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	13,403.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,822.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,309.00	330.00			
AUDIOLOGY	1,654.00	0.00			
CARDIOLOGY	7,188.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,882.00	0.00			

TOTAL ANCILLARY	649,569.00	27,027.00
TOTAL ACCOMODATIONS	622,400.00	0.00
TOTAL CHARGES	1,271,969.00	27,027.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,850,348.67	ADJUSTMENTS	623,370.80
COVERED CHARGES	17,878,670.17	CONTRACTUAL ALLOW	15,699,063.17
NON-COVERD CHARGES	1,971,678.50	TOTAL MEDICAID LIAB	2,179,607.00
		LESS: COB	3,628.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,175,978.36
		ALL OTHER	1,893,252.32
		FEE SCHEDULE-LAB	183,760.35
		INJECTABLE DRUGS	98,965.69

TOTAL NUMBER OF CLAIMS 2,762

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	817,492.00	24,804.50
MED/SURG SUPPLY	278,980.00	7,609.00
LABORATORY-GENERAL	0.00	531.00
RADIOLOGY-DIAGNOSTIC	445,966.00	6,220.00
CT SCAN	2,545,380.00	251,212.00
PHYSICAL THERAPY	164,354.00	26,826.00
EKG/ECG	226,136.00	468.00
IV THERAPY	725,282.00	12,398.00
OPERATING ROOM	1,416,053.00	323,022.00
LABOR/DELIVERY ROOM	55,800.00	0.00
RESPIRATORY SERVICES	55,468.00	1,822.00
ANESTHESIA	370,769.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,606,242.00	19,169.00
RECOVERY ROOM	328,295.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,543,416.00	46,970.00
OCCUPATIONAL THERAPY	19,519.00	13,427.00
SPEECH PATHOLOGY	2,376.00	9,003.00
RENAL DIALYSIS	0.00	39,408.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	83,479.00	2,108.00
PSYCHIATRIC SERVICES	15,147.00	13,464.00
LITHOTRIPSY	29,804.00	0.00
OTHER IMAGING SERVICE	752,976.00	59,174.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	59,653.00	33,419.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	67,665.00	21,046.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	207,067.00	121,799.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,036.00	12,408.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	93,031.67	29,258.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	142,801.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	312.00	0.00
OTHER THERAPEUTIC SVC	0.00	507.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,484,900.00	160,793.00
MRI SERVICES	969,381.00	91,883.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	7,201.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,608.00
INJECTABLE DRUGS	1,181,964.50	629,170.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	172,925.00	1,951.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,878,670.17	1,971,678.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,878,670.17	1,971,678.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	565,023.00	ADJUSTMENTS	0.00
COVERED CHARGES	335,010.00	CONTRACTUAL ALLOW	293,547.66
NON-COVERD CHARGES	230,013.00	TOTAL MEDICAID LIAB	41,462.34
		LESS: COB	41,462.34
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,392.00	0.00
MED/SURG SUPPLY	6,112.00	3,008.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,210.00	0.00
CT SCAN	19,220.00	61,356.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,808.00	0.00
IV THERAPY	10,301.00	0.00
OPERATING ROOM	32,936.00	85,852.00
LABOR/DELIVERY ROOM	7,622.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	26,626.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	80,404.00	2,234.00
RECOVERY ROOM	18,392.00	374.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	258.00	0.00
PSYCHIATRIC SERVICES	561.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	18,662.00	24,318.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,848.00	946.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	735.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,350.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,914.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,182.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,814.00	3,232.00
MRI SERVICES	0.00	25,191.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,674.00	17,017.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	9,989.00	6,485.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	335,010.00	230,013.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	335,010.00	230,013.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	670,524.48	ADJUSTMENTS	738.43
COVERED CHARGES	597,127.98	CONTRACTUAL ALLOW	588,468.21
NON-COVERD CHARGES	73,396.50	TOTAL MEDICAID LIAB	8,659.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,659.77

TOTAL NUMBER OF CLAIMS 129

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,592.00	0.00	OTHER LAB	1,182.00	0.00
MED/SURG SUPPLY	4,163.00	6,692.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,045.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,037.00	30,608.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	129,123.00	4,004.00
EKG/ECG	12,168.00	0.00	MRI SERVICES	0.00	11,979.00
IV THERAPY	28,808.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,723.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,020.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	254,701.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,720.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,300.50	3,913.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	561.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	18,177.00	8,624.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,752.00	7,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,055.48	0.00			

TOTAL ANCILLARY	597,127.98	73,396.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	597,127.98	73,396.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,885.00	ADJUSTMENTS	0.00
COVERED CHARGES	41,550.50	CONTRACTUAL ALLOW	40,879.20
NON-COVERD CHARGES	8,334.50	TOTAL MEDICAID LIAB	671.30
		LESS: COB	671.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,845.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	558.00	0.00
CT SCAN	3,614.00	6,146.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	936.00	0.00
IV THERAPY	2,563.00	249.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,779.00	516.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	561.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,441.00	833.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	814.50	29.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	41,550.50	8,334.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,550.50	8,334.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,173,566.54	ADJUSTMENTS	90,291.33
COVERED CHARGES	5,732,307.70	CONTRACTUAL ALLOW	5,267,236.52
NON-COVERD CHARGES	441,258.84	TOTAL MEDICAID LIAB	465,071.18
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	465,071.18

TOTAL NUMBER OF CLAIMS 92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,994.50	2,964.50
MED/SURG SUPPLY	333,942.00	24,895.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,603.00	0.00
CT SCAN	11,117.00	4,843.00
PHYSICAL THERAPY	0.00	13,610.00
EKG/ECG	6,552.00	0.00
IV THERAPY	87,164.00	0.00
OPERATING ROOM	1,154,317.66	204,989.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,914.00	0.00
ANESTHESIA	212,579.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,986.00	3,393.00
RECOVERY ROOM	125,240.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	332,452.00	0.00
OCCUPATIONAL THERAPY	0.00	5,050.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,063.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,149.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,751.00	2,301.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,459.00	9,659.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	71,733.00	27,889.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,092.04	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,395.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	117,850.00	7,204.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,844,835.50	71,321.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,168,119.00	63,140.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,732,307.70	441,258.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,732,307.70	441,258.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,695,052.29	ADJUSTMENTS	8,010.86
COVERED CHARGES	1,684,508.40	CONTRACTUAL ALLOW	1,364,832.02
NON-COVERD CHARGES	10,543.89	TOTAL MEDICAID LIAB	319,676.38
		LESS: COB	2,799.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	3,000.00
		REIMBURSEMENT	319,877.36

TOTAL NUMBER OF ADMISSIONS 53

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	144	0	155,783.00	0.00
ROUTINE NURSERY	14	0	6,209.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	158	0	161,992.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,044.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	3,044.00	0.00
TOTAL ACCOMODATIONS	160	0	165,036.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	359,973.92	0.00
MED/SURG SUPPLY	54,779.28	0.00
LABORATORY-GENERAL	123,836.83	0.00
RADIOLOGY-DIAGNOSTIC	7,669.17	0.00
CT SCAN	66,137.38	0.00
PHYSICAL THERAPY	13,865.51	0.00
EKG/ECG	4,414.96	0.00
IV THERAPY	166,351.95	0.00
OPERATING ROOM	163,211.63	0.00
LABOR/DELIVERY ROOM	865.49	0.00
RESPIRATORY SERVICES	57,041.32	0.00
ANESTHESIA	32,866.00	0.00
GI SERVICES	22,200.45	0.00
EMERGENCY ROOM	79,525.30	0.00
RECOVERY ROOM	19,272.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,193.50	0.00
SPEECH PATHOLOGY	1,066.16	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,003.07	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,245.58	5,037.81
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,921.41	0.00
AUDIOLOGY	0.00	2,233.36
CARDIOLOGY	17,734.13	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	286,850.52	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,648.18	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	393.08	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,405.58	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	3,272.72
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,519,472.40	10,543.89
TOTAL ACCOMODATIONS	165,036.00	0.00
TOTAL CHARGES	1,684,508.40	10,543.89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER 000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,070,262.42	ADJUSTMENTS	48,472.59
COVERED CHARGES	5,414,415.80	CONTRACTUAL ALLOW	4,500,659.58
NON-COVERD CHARGES	655,846.62	TOTAL MEDICAID LIAB	913,756.22
		LESS: COB	3,831.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	909,925.01
		ALL OTHER	803,362.41
		FEE SCHEDULE-LAB	100,839.19
		INJECTABLE DRUGS	5,723.41

TOTAL NUMBER OF CLAIMS 1,929

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,476.43	22,319.43
MED/SURG SUPPLY	90,106.05	6,525.20
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	318,728.66	2,040.02
CT SCAN	837,227.95	138,536.06
PHYSICAL THERAPY	120,177.53	6,270.11
EKG/ECG	40,533.00	2,825.85
IV THERAPY	357,550.40	79,334.33
OPERATING ROOM	106,144.86	42,514.97
LABOR/DELIVERY ROOM	2,379.21	0.00
RESPIRATORY SERVICES	35,638.12	9,856.54
ANESTHESIA	199,712.00	0.00
GI SERVICES	210,814.65	82,821.00
EMERGENCY ROOM	1,198,996.26	1,785.58
RECOVERY ROOM	63,276.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	44,212.62	4,717.74
SPEECH PATHOLOGY	1,788.29	858.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	738.00	1,566.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	158,487.28	13,344.97
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,416.29	581.56
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	49,768.39	110.40
AUDIOLOGY	0.00	0.00
CARDIOLOGY	36,472.43	19,414.47
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	459,297.76	1,290.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	60,548.39	1,055.40
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	57.66	363.44
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	503,666.75	153,116.67
MRI SERVICES	60,682.52	11,127.48
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	137,239.80	52,400.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,278.10	1,071.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,414,415.80	655,846.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,414,415.80	655,846.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,271.16	ADJUSTMENTS	0.00
COVERED CHARGES	20,215.79	CONTRACTUAL ALLOW	16,963.76
NON-COVERD CHARGES	6,055.37	TOTAL MEDICAID LIAB	3,252.03
		LESS: COB	3,252.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,409.00	0.00
MED/SURG SUPPLY	13.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,607.47	0.00
CT SCAN	5,314.00	3,320.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	135.35	0.00
IV THERAPY	1,242.08	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,771.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	464.40	200.99
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,850.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,969.49	684.18
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	290.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,215.79	6,055.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,215.79	6,055.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	207,107.58	ADJUSTMENTS	70.00
COVERED CHARGES	186,751.78	CONTRACTUAL ALLOW	179,191.78
NON-COVERD CHARGES	20,355.80	TOTAL MEDICAID LIAB	7,560.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,560.00

TOTAL NUMBER OF CLAIMS 108

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,653.60	604.00
MED/SURG SUPPLY	1,682.91	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,267.31	93.66
CT SCAN	20,796.46	3,610.35
PHYSICAL THERAPY	0.00	3,871.89
EKG/ECG	947.74	0.00
IV THERAPY	8,028.88	2,024.63
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	615.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	109,289.73	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	142.66	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,514.29	7,563.08
MRI SERVICES	0.00	2,388.19
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,812.80	200.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	186,751.78	20,355.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	186,751.78	20,355.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,728.69	ADJUSTMENTS	0.00
COVERED CHARGES	1,493.89	CONTRACTUAL ALLOW	1,423.89
NON-COVERD CHARGES	234.80	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156.00	50.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54.56	184.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	157.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	970.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	135.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,493.89	234.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,493.89	234.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,027,164.71	ADJUSTMENTS	9,152.36
COVERED CHARGES	957,513.36	CONTRACTUAL ALLOW	837,186.21
NON-COVERD CHARGES	69,651.35	TOTAL MEDICAID LIAB	120,327.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	120,327.15

TOTAL NUMBER OF CLAIMS 26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,945.87	1,192.00
MED/SURG SUPPLY	42,191.33	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,709.70	103.26
CT SCAN	35,868.48	4,451.15
PHYSICAL THERAPY	0.00	2,196.81
EKG/ECG	1,860.42	312.00
IV THERAPY	177,380.09	19,363.37
OPERATING ROOM	97,908.40	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,931.23	11,981.20
ANESTHESIA	49,519.00	0.00
GI SERVICES	0.00	8,908.80
EMERGENCY ROOM	42,412.40	0.00
RECOVERY ROOM	15,417.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,489.59
SPEECH PATHOLOGY	0.00	214.61
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 SERVICE	1,560.27	158.72
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,751.81	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,700.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	338,210.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,055.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	38.44	66.96
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,391.04	11,007.88
MRI SERVICES	2,723.88	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,848.00	6,205.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	957,513.36	69,651.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	957,513.36	69,651.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/22 THROUGH 11/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	62,031,917.78	ADJUSTMENTS	2,079,774.69
COVERED CHARGES	61,517,238.56	CONTRACTUAL ALLOW	48,148,534.03
NON-COVERD CHARGES	514,679.22	TOTAL MEDICAID LIAB	13,368,704.53
		LESS: COB	249,592.88
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	5,166.00
		REIMBURSEMENT	13,124,277.65

TOTAL NUMBER OF ADMISSIONS 1,163

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,010	0	5,908,596.00	0.00
ROUTINE NURSERY	794	0	1,039,488.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	66.00
TOTAL ROUTINE	5,804	0	6,948,084.00	66.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,277	0	3,586,483.00	0.00
NICU	13	0	57,070.00	0.00
PED ICU	23	0	63,365.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,313	0	3,706,918.00	0.00
TOTAL ACCOMODATIONS	7,117	0	10,655,002.00	66.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,178,988.94	0.00
MED/SURG SUPPLY	1,818,612.59	0.00
LABORATORY-GENERAL	14,224,362.00	0.00
RADIOLOGY-DIAGNOSTIC	828,382.00	0.00
CT SCAN	2,542,035.00	32,758.00
PHYSICAL THERAPY	345,494.00	0.00
EKG/ECG	258,554.00	0.00
IV THERAPY	1,375,976.00	0.00
OPERATING ROOM	3,732,232.00	0.00
LABOR/DELIVERY ROOM	575,973.00	294.00
RESPIRATORY SERVICES	4,416,078.00	0.00
ANESTHESIA	458,310.00	0.00
GI SERVICES	414,490.00	0.00
EMERGENCY ROOM	2,879,185.00	0.00
RECOVERY ROOM	694,625.00	0.00
LABORATORY PATHOLOGIC	427,296.00	0.00
RADIOLOGY THERAPEUTIC	33,102.00	0.00
OCCUPATIONAL THERAPY	569,959.00	0.00
SPEECH PATHOLOGY	118,857.00	0.00
RENAL DIALYSIS	604,607.00	6,448.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	42,214.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	241,124.00	6,828.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	513,544.00	248,718.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,168.00	17,601.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,126,142.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	143,012.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	341,644.39	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	166,804.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	565,500.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,668.22
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	199,298.00
IMPL DEV CHARGE PATIENTS	1,181,067.64	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	4,898.00	0.00

TOTAL ANCILLARY	50,862,236.56	514,613.22
TOTAL ACCOMODATIONS	10,655,002.00	66.00
TOTAL CHARGES	61,517,238.56	514,679.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2323257000113	06/08/23 - 06/28/23	09/18/23	2,449.00	0.00	0.00	5,192.04	0.00
615	2023259022321	12/08/22 - 01/25/23	09/25/23	2,449.00	0.00	0.00	0.00	0.00
TOTAL				4,898.00	0.00	0.00	5,192.04	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	346,618.57	ADJUSTMENTS	0.00
COVERED CHARGES	346,324.57	CONTRACTUAL ALLOW	268,514.08
NON-COVERD CHARGES	294.00	TOTAL MEDICAID LIAB	77,810.49
		LESS: COB	77,936.49
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	126.00
		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	33	0	40,230.00	0.00
ROUTINE NURSERY	4	0	3,468.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	37	0	43,698.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	2,504.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	2,504.00	0.00
TOTAL ACCOMODATIONS	38	0	46,202.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,078.32	0.00	OTHER LAB	1,432.00	0.00
MED/SURG SUPPLY	7,309.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	65,319.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,583.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,445.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,733.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	729.00	0.00	MRI SERVICES	3,066.00	0.00
IV THERAPY	8,003.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,562.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,917.00	294.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,742.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,153.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,155.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,159.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	657.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,456.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	757.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	442.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,088.17	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,840.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,497.05	0.00			

TOTAL ANCILLARY	300,122.57	294.00
TOTAL ACCOMODATIONS	46,202.00	0.00
TOTAL CHARGES	346,324.57	294.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,972,619.89	ADJUSTMENTS	672,600.46
COVERED CHARGES	31,871,256.07	CONTRACTUAL ALLOW	26,865,493.90
NON-COVERD CHARGES	4,101,363.82	TOTAL MEDICAID LIAB	5,005,762.17
		LESS: COB	8,858.58
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,996,903.59
		ALL OTHER	3,414,403.48
		FEE SCHEDULE-LAB	262,703.82
		INJECTABLE DRUGS	1,319,796.29

TOTAL NUMBER OF CLAIMS 11,625

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449,298.63	6,918.08
MED/SURG SUPPLY	577,200.67	70,295.51
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	792,536.00	30,717.00
CT SCAN	1,807,416.00	273,494.00
PHYSICAL THERAPY	29,717.00	11,486.00
EKG/ECG	194,025.00	4,131.00
IV THERAPY	2,324,706.00	173,415.00
OPERATING ROOM	1,889,879.94	272,087.06
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	163,979.00	35,153.00
ANESTHESIA	259,965.00	0.00
GI SERVICES	322,782.00	173,893.00
EMERGENCY ROOM	6,315,626.03	6,506.00
RECOVERY ROOM	496,653.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,640,142.00	63,211.00
OCCUPATIONAL THERAPY	14,436.00	15,992.00
SPEECH PATHOLOGY	2,557.00	6,156.00
RENAL DIALYSIS	0.00	138,193.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	764.00	21,713.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	639,358.00	39,071.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	179,872.00	9,708.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,781.00	70,180.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	153,434.00	61,673.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,443.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,799,296.63	20,720.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	112,857.00	1,432.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	1,308.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,085,131.00	313,477.00
MRI SERVICES	107,795.00	67,715.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	34,941.50
INJECTABLE DRUGS	6,409,557.00	1,852,430.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	154,003.00
IMPL DEV CHARGE PATIENTS	27,048.17	171,343.84
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	31,871,256.07	4,101,363.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,871,256.07	4,101,363.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	318,407.36	ADJUSTMENTS	0.00
COVERED CHARGES	282,256.50	CONTRACTUAL ALLOW	240,542.22
NON-COVERD CHARGES	36,150.86	TOTAL MEDICAID LIAB	41,714.28
		LESS: COB	41,714.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 115

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,190.73	249.60
MED/SURG SUPPLY	4,100.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,932.00	330.00
CT SCAN	14,818.00	16,716.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,458.00	243.00
IV THERAPY	17,564.00	557.00
OPERATING ROOM	35,923.14	9,026.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,128.00	0.00
ANESTHESIA	6,555.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,510.00	195.00
RECOVERY ROOM	14,838.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	688.00	277.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	367.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	191.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,035.00	470.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,128.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,417.00	5,665.00
MRI SERVICES	6,995.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,930.03	1,863.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	45.79	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	282,256.50	36,150.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	282,256.50	36,150.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	968,088.95	ADJUSTMENTS	469.91
COVERED CHARGES	939,116.12	CONTRACTUAL ALLOW	902,463.13
NON-COVERD CHARGES	28,972.83	TOTAL MEDICAID LIAB	36,652.99
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	36,652.99

TOTAL NUMBER OF CLAIMS 547

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,801.14	0.00
MED/SURG SUPPLY	283.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,927.00	811.00
CT SCAN	37,582.00	3,417.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,346.00	0.00
IV THERAPY	71,766.00	4,943.00
OPERATING ROOM	408.00	649.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	227.00	1,546.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	608,041.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,350.00	435.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,204.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,760.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	154,216.00	1,158.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,204.97	6,954.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	9,059.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	939,116.12	28,972.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	939,116.12	28,972.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,076.75	ADJUSTMENTS	0.00
COVERED CHARGES	26,882.66	CONTRACTUAL ALLOW	26,278.49
NON-COVERD CHARGES	3,194.09	TOTAL MEDICAID LIAB	604.17
		LESS: COB	604.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111.16	166.40
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,520.00	0.00
CT SCAN	0.00	2,814.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,768.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,937.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,476.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,782.00	135.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	288.50	78.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	26,882.66	3,194.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,882.66	3,194.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,792,348.78	ADJUSTMENTS	164,563.48
COVERED CHARGES	6,267,758.57	CONTRACTUAL ALLOW	5,526,696.79
NON-COVERD CHARGES	524,590.21	TOTAL MEDICAID LIAB	741,061.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	741,061.78

TOTAL NUMBER OF CLAIMS 126

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,175.74	719.68
MED/SURG SUPPLY	89,913.32	56,007.66
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,785.00	0.00
CT SCAN	2,171.00	5,049.00
PHYSICAL THERAPY	0.00	298.00
EKG/ECG	1,215.00	0.00
IV THERAPY	70,991.00	459.00
OPERATING ROOM	315,250.67	13,950.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	527.00	188.00
ANESTHESIA	31,193.00	0.00
GI SERVICES	58,215.00	4,695.00
EMERGENCY ROOM	2,620.00	0.00
RECOVERY ROOM	72,088.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	115,217.00	0.00
OCCUPATIONAL THERAPY	0.00	436.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,902.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	831.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,204.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	38,342.00	82,087.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	68,559.77	2,092.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	43,421.00	27,248.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,253,631.03	263,983.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	56,408.04	64,475.02
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,267,758.57	524,590.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,267,758.57	524,590.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/23	THROUGH	12/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	156,808,819.86	ADJUSTMENTS	3,366,205.38
COVERED CHARGES	153,850,449.91	CONTRACTUAL ALLOW	128,787,548.81
NON-COVERD CHARGES	2,958,369.95	TOTAL MEDICAID LIAB	25,062,901.10
		LESS: COB	409,318.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	30,000.00
		REIMBURSEMENT	24,683,582.66

TOTAL NUMBER OF ADMISSIONS 2,055

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,487	0	7,514,212.97	0.00
ROUTINE NURSERY	2,567	0	13,465,128.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.94
TOTAL ROUTINE	8,054	0	20,979,340.97	0.94
SPECIAL CARE SERVICES				
CCU	3,898	0	14,397,456.00	0.00
ICU	2,975	0	11,383,970.00	0.00
NICU	197	0	1,949,033.00	0.00
PED ICU	340	0	1,382,085.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	144	0	584,064.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,554	0	29,696,608.00	0.00
TOTAL ACCOMODATIONS	15,608	0	50,675,948.97	0.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,816,398.70	53,406.07
MED/SURG SUPPLY	3,733,160.47	86,026.89
LABORATORY-GENERAL	16,476,546.91	6,549.70
RADIOLOGY-DIAGNOSTIC	1,974,648.65	1,526.40
CT SCAN	6,230,374.02	52,394.85
PHYSICAL THERAPY	855,861.25	0.00
EKG/ECG	536,254.65	235.35
IV THERAPY	1,348,311.05	0.00
OPERATING ROOM	10,137,260.62	0.00
LABOR/DELIVERY ROOM	1,091,398.60	1,328.40
RESPIRATORY SERVICES	10,700,088.85	0.00
ANESTHESIA	1,652,811.65	0.00
GI SERVICES	771,477.00	0.00
EMERGENCY ROOM	5,320,330.15	0.00
RECOVERY ROOM	1,358,626.30	0.00
LABORATORY PATHOLOGIC	185,991.00	0.00
RADIOLOGY THERAPEUTIC	132,118.55	0.00
OCCUPATIONAL THERAPY	517,602.45	0.00
SPEECH PATHOLOGY	322,440.65	0.00
RENAL DIALYSIS	1,231,749.65	1,295,891.60
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	29,231.00	45,453.95
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	707,009.35	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,209,664.95	707,035.95
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	248,228.95	42,437.05
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,495,057.35	4,082.55
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	266,222.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,315,282.65	85,912.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	369,690.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,150.30	0.00
OTHER THERAPEUTIC SVC	1,186,594.35	2,533.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,751,877.44	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	107,221.85
INJECTABLE DRUGS	2,631,257.85	450.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	465,882.05
IMPL DEV CHARGE PATIENTS	5,513,678.71	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	54,103.77	0.00

TOTAL ANCILLARY	103,174,500.94	2,958,369.01
TOTAL ACCOMODATIONS	50,675,948.97	0.94
TOTAL CHARGES	153,850,449.91	2,958,369.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023109062408	04/09/23 - 04/13/23	04/24/23	3,850.80	0.00	0.00	0.00	0.00
615	2023116068840	04/09/23 - 04/20/23	05/01/23	7,701.60	0.00	0.00	0.00	0.00
615	2023117083366	04/07/23 - 04/20/23	05/01/23	7,701.60	0.00	0.00	0.00	0.00
615	2023125089844	04/24/23 - 04/28/23	05/15/23	3,850.80	0.00	0.00	0.00	0.00
615	2023179073346	06/17/23 - 06/24/23	07/03/23	3,850.80	0.00	0.00	0.00	0.00
615	2023238011973	08/21/23 - 08/22/23	09/04/23	3,850.80	0.00	0.00	0.00	0.00
615	2223324006065	08/14/23 - 09/05/23	11/27/23	3,850.80	0.00	0.00	0.00	0.00
615	2224009004625	11/21/23 - 12/10/23	01/15/24	7,701.60	0.00	0.00	0.00	0.00
615	2024114066143	12/13/23 - 01/08/24	04/29/24	4,043.35	0.00	0.00	0.00	0.00
615	5224170000533	10/30/23 - 11/22/23	06/24/24	7,701.62	0.00	0.00	5,747.51	0.00
TOTAL				54,103.77	0.00	0.00	5,747.51	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,429,152.39	ADJUSTMENTS	0.00
COVERED CHARGES	2,419,944.63	CONTRACTUAL ALLOW	2,029,763.73
NON-COVERD CHARGES	9,207.76	TOTAL MEDICAID LIAB	390,180.90
		LESS: COB	390,180.90
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 52

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	133	0	181,861.00	0.00
ROUTINE NURSERY	44	0	189,184.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.31
TOTAL ROUTINE	177	0	371,045.00	0.31
SPECIAL CARE SERVICES				
CCU	30	0	112,275.00	0.00
ICU	54	0	208,198.00	0.00
NICU	0	0	0.00	0.00
PED ICU	7	0	28,392.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	91	0	348,865.00	0.00
TOTAL ACCOMODATIONS	268	0	719,910.00	0.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,405.58	0.00
MED/SURG SUPPLY	35,666.14	0.00
LABORATORY-GENERAL	272,509.14	0.00
RADIOLOGY-DIAGNOSTIC	31,423.65	0.00
CT SCAN	86,213.48	3,212.10
PHYSICAL THERAPY	6,819.25	0.00
EKG/ECG	8,242.65	0.00
IV THERAPY	24,526.80	0.00
OPERATING ROOM	127,963.30	0.00
LABOR/DELIVERY ROOM	127,374.80	0.00
RESPIRATORY SERVICES	130,462.55	0.00
ANESTHESIA	41,281.10	0.00
GI SERVICES	18,847.40	0.00
EMERGENCY ROOM	95,724.00	0.00
RECOVERY ROOM	25,890.00	0.00
LABORATORY PATHOLOGIC	3,741.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,707.80	0.00
SPEECH PATHOLOGY	5,958.65	0.00
RENAL DIALYSIS	35,522.75	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	550.50	752.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,729.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,471.80	3,167.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,909.00	699.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	69,820.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	47,876.15	1,092.35

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,355.65	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	119.20	0.00
OTHER THERAPEUTIC SVC	15,557.65	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	16,628.30	0.00
PROFESSIONAL FEES	0.00	284.05
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,924.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,811.14	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,700,034.63	9,207.45
TOTAL ACCOMODATIONS	719,910.00	0.31
TOTAL CHARGES	2,419,944.63	9,207.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	53,501,601.35	ADJUSTMENTS	1,369,887.44
COVERED CHARGES	48,305,428.94	CONTRACTUAL ALLOW	40,835,153.12
NON-COVERD CHARGES	5,196,172.41	TOTAL MEDICAID LIAB	7,470,275.82
		LESS: COB	45,223.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,425,052.80
		ALL OTHER	5,730,059.36
		FEE SCHEDULE-LAB	702,246.44
		INJECTABLE DRUGS	992,747.00

TOTAL NUMBER OF CLAIMS 15,432

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	679,583.40	206.85
MED/SURG SUPPLY	841,788.54	969.84
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,499,100.70	42,596.95
CT SCAN	3,198,972.50	609,256.00
PHYSICAL THERAPY	0.00	4,969.95
EKG/ECG	245,017.95	20,733.30
IV THERAPY	562,758.50	55,315.90
OPERATING ROOM	3,897,584.94	1,116,026.06
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	275,969.45	34,233.10
ANESTHESIA	732,232.60	446.05
GI SERVICES	811,185.57	155,029.48
EMERGENCY ROOM	9,647,021.55	16,584.85
RECOVERY ROOM	1,746,446.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	291,192.50	3,073.95
OCCUPATIONAL THERAPY	0.00	1,327.05
SPEECH PATHOLOGY	38,791.20	7,359.45
RENAL DIALYSIS	0.00	45,348.45
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,048,669.40	150,339.86
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	536,735.90	83,081.65
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	462,756.65	44,652.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	225,385.65	88,259.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,017,013.35	502,073.35
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	124,047.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,238,883.55	98,479.15

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	154,339.65	6,527.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	463.25
OTHER THERAPEUTIC SVC	773,416.75	149,157.45
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,943,179.43	246,689.65
MRI SERVICES	414,105.75	67,532.65
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,375.60
INJECTABLE DRUGS	8,598,063.84	1,284,802.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	247,254.40
IMPL DEV CHARGE PATIENTS	301,185.32	93,603.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	15,403.20

TOTAL ANCILLARY	48,305,428.94	5,196,172.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,305,428.94	5,196,172.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023038044411	02/03/23 - 02/03/23	02/13/23	0.00	3,850.80	0.00	0.00	0.00
615	2023097058886	04/03/23 - 04/03/23	04/10/23	0.00	3,850.80	0.00	0.00	0.00
615	2023262032937	09/15/23 - 09/15/23	09/25/23	0.00	3,850.80	0.00	0.00	0.00
615	2023262032960	09/15/23 - 09/15/23	09/25/23	0.00	3,850.80	0.00	0.00	0.00
TOTAL				0.00	15,403.20	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,554,089.51	ADJUSTMENTS	0.00
COVERED CHARGES	839,889.06	CONTRACTUAL ALLOW	707,572.15
NON-COVERD CHARGES	714,200.45	TOTAL MEDICAID LIAB	132,316.91
		LESS: COB	132,316.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 324

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,826.50	0.00
MED/SURG SUPPLY	10,956.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,235.65	0.00
CT SCAN	14,087.60	67,935.40
PHYSICAL THERAPY	0.00	523.45
EKG/ECG	5,413.05	0.00
IV THERAPY	24,969.30	810.80
OPERATING ROOM	52,448.60	36,671.70
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	993.65	224.95
ANESTHESIA	15,673.35	0.00
GI SERVICES	5,723.05	11,959.85
EMERGENCY ROOM	240,148.00	264.55
RECOVERY ROOM	53,910.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	6,006.80	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	726.15	1,452.30
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,070.70	868.35
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,274.25	2,923.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,688.95	2,111.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,595.55	911.70
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,407.90	119,366.85
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,808.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	49,999.05	3,226.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,400.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	20,608.05	3,103.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	168,288.35	2,668.00
MRI SERVICES	5,455.75	53,627.45
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,292.95	393,072.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	11,657.65
IMPL DEV CHARGE PATIENTS	6,880.16	819.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	839,889.06	714,200.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	839,889.06	714,200.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,698,896.96	ADJUSTMENTS	671.30
COVERED CHARGES	1,663,851.26	CONTRACTUAL ALLOW	1,625,587.16
NON-COVERD CHARGES	35,045.70	TOTAL MEDICAID LIAB	38,264.10
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	38,264.10

TOTAL NUMBER OF CLAIMS 570

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,077.15	0.00
MED/SURG SUPPLY	1,253.06	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,853.20	459.65
CT SCAN	70,727.20	18,011.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,944.25	0.00
IV THERAPY	7,898.40	457.80
OPERATING ROOM	5,477.40	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,415.10	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,228,675.70	1,418.65
RECOVERY ROOM	1,140.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,237.95	529.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,585.35	3,777.70
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	4,082.55
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	18,162.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,984.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	22,394.15	476.65
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	196,759.30	5,806.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,265.35	25.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,663,851.26	35,045.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,663,851.26	35,045.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	156,908.05	ADJUSTMENTS	0.00
COVERED CHARGES	132,735.75	CONTRACTUAL ALLOW	130,587.59
NON-COVERD CHARGES	24,172.30	TOTAL MEDICAID LIAB	2,148.16
		LESS: COB	2,148.16
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 32

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	814.70	0.00
MED/SURG SUPPLY	187.65	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,135.40	0.00
CT SCAN	10,573.10	20,064.10
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,882.80	0.00
IV THERAPY	987.30	0.00
OPERATING ROOM	2,772.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	87,029.55	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,441.35	747.90
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	2,871.25
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	580.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	2,145.45	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,710.15	464.05
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	475.00	25.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	132,735.75	24,172.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	132,735.75	24,172.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,256,755.45	ADJUSTMENTS	154,923.33
COVERED CHARGES	19,420,260.06	CONTRACTUAL ALLOW	17,982,553.02
NON-COVERD CHARGES	1,836,495.39	TOTAL MEDICAID LIAB	1,437,707.04
		LESS: COB	8,620.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,429,086.28

TOTAL NUMBER OF CLAIMS 230

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,455.10	0.00
MED/SURG SUPPLY	1,723,645.02	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,923.75	6,910.15
CT SCAN	11,967.30	4,683.80
PHYSICAL THERAPY	0.00	2,347.80
EKG/ECG	7,295.85	15,064.20
IV THERAPY	47,473.10	5,250.90
OPERATING ROOM	2,000,515.09	384,428.27
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	77,535.95	736.00
ANESTHESIA	304,118.65	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,625.40	0.00
RECOVERY ROOM	781,592.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	15,664.60	0.00
OCCUPATIONAL THERAPY	0.00	1,559.25
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	376.00	2,632.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,505.95	12,371.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	414.90	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,774.55	649.35
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,806,560.70	1,165,585.55
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	122,114.90	374.15

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,813.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	9,132.20	26,493.55
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	135,921.40	1,680.57
MRI SERVICES	4,145.60	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,691,352.35	73,615.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,381,335.90	132,112.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,420,260.06	1,836,495.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,420,260.06	1,836,495.39

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	387,238.35	ADJUSTMENTS	0.00
COVERED CHARGES	331,478.95	CONTRACTUAL ALLOW	312,222.88
NON-COVERD CHARGES	55,759.40	TOTAL MEDICAID LIAB	19,256.07
		LESS: COB	19,256.07
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

THE MEDICAL CENTER OF CENTRAL GEORGIA INC
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,464.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	85,977.76	7,700.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	441.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107.80	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,315.15	47,984.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,602.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,843.50	75.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	201,477.14	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	331,478.95	55,759.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	331,478.95	55,759.40

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/23	THROUGH	12/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,158,650.98	ADJUSTMENTS	303,293.63
COVERED CHARGES	27,741,859.46	CONTRACTUAL ALLOW	23,947,077.07
NON-COVERD CHARGES	416,791.52	TOTAL MEDICAID LIAB	3,794,782.39
		LESS: COB	23,025.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,323.00
		REIMBURSEMENT	3,773,080.01

TOTAL NUMBER OF ADMISSIONS 452

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,630	0	3,888,423.50	0.00
ROUTINE NURSERY	40	0	59,037.75	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,670	0	3,947,461.25	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	524	0	2,215,746.75	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	524	0	2,215,746.75	0.00
TOTAL ACCOMODATIONS	2,194	0	6,163,208.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660,109.33	0.02
MED/SURG SUPPLY	849,342.50	235.50
LABORATORY-GENERAL	2,346,966.07	6,226.75
RADIOLOGY-DIAGNOSTIC	464,552.25	562.50
CT SCAN	1,502,248.66	141,343.00
PHYSICAL THERAPY	293,637.96	0.00
EKG/ECG	251,646.69	1,194.50
IV THERAPY	26,959.00	404.25
OPERATING ROOM	1,520,101.50	37,686.50
LABOR/DELIVERY ROOM	81,595.25	0.00
RESPIRATORY SERVICES	2,675,962.50	0.00
ANESTHESIA	777,924.95	0.00
GI SERVICES	470,949.00	10,317.25
EMERGENCY ROOM	2,459,472.00	0.00
RECOVERY ROOM	56,315.75	0.00
LABORATORY PATHOLOGIC	139,638.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	186,573.71	0.00
SPEECH PATHOLOGY	60,106.00	0.00
RENAL DIALYSIS	698,823.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,398.75	3,111.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	246,883.25	13,637.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	133,841.00	135,726.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	246,934.50	57,834.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,168,513.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	53,895.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	112,519.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	138,167.29	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,991.00	0.00
OTHER THERAPEUTIC SVC	0.00	7,548.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	316,480.75	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,215,699.50	963.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	407,402.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,578,651.46	416,791.52
TOTAL ACCOMODATIONS	6,163,208.00	0.00
TOTAL CHARGES	27,741,859.46	416,791.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	92,651.27	ADJUSTMENTS	0.00
COVERED CHARGES	92,651.27	CONTRACTUAL ALLOW	81,824.54
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,826.73
		LESS: COB	10,826.73
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7	0	18,054.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	18,054.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	18,054.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,179.27	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,750.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,260.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,833.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,421.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,723.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,252.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,541.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,139.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	3,495.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,597.27	0.00
TOTAL ACCOMODATIONS	18,054.00	0.00
TOTAL CHARGES	92,651.27	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,870,586.07	ADJUSTMENTS	177,044.79
COVERED CHARGES	24,194,185.72	CONTRACTUAL ALLOW	22,293,053.87
NON-COVERD CHARGES	2,676,400.35	TOTAL MEDICAID LIAB	1,901,131.85
		LESS: COB	625.57
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,900,506.28
		ALL OTHER	1,766,416.91
		FEE SCHEDULE-LAB	134,060.24
		INJECTABLE DRUGS	29.13
		TOTAL NUMBER OF CLAIMS	4,773

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	240,413.93	143.79
MED/SURG SUPPLY	392,846.97	22,174.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,239,014.00	38,709.75
CT SCAN	3,081,134.50	319,590.00
PHYSICAL THERAPY	38,808.75	26,791.75
EKG/ECG	386,456.75	14,023.25
IV THERAPY	1,600,291.75	0.00
OPERATING ROOM	1,728,632.38	698,281.62
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	384,894.50	8,131.50
ANESTHESIA	1,458,651.50	0.00
GI SERVICES	916,661.00	122,462.75
EMERGENCY ROOM	6,490,227.75	8,304.25
RECOVERY ROOM	314,853.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,519.50	6,402.25
SPEECH PATHOLOGY	0.00	12,396.50
RENAL DIALYSIS	0.00	55,640.24
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	137,325.50	1,555.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	591,424.75	90,409.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	54,161.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	312,390.75	124,905.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	347,563.00	197,258.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	350,934.25	2,876.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	363,268.72	591,280.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	241,201.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,793.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,418,767.45	51,001.45
MRI SERVICES	958,341.75	110,504.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,857.77	691.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	124,543.00	171,072.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,194,185.72	2,676,400.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,194,185.72	2,676,400.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	254,767.72	ADJUSTMENTS	0.00
COVERED CHARGES	159,302.07	CONTRACTUAL ALLOW	146,894.13
NON-COVERD CHARGES	95,465.65	TOTAL MEDICAID LIAB	12,407.94
		LESS: COB	12,407.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,309.77	0.00
MED/SURG SUPPLY	2,055.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,173.00	0.00
CT SCAN	2,749.25	42,854.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,791.75	0.00
IV THERAPY	4,185.50	0.00
OPERATING ROOM	0.00	17,364.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	793.00
ANESTHESIA	13,447.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	80,512.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,658.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,758.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	6,652.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,746.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,863.55	765.40
MRI SERVICES	7,286.50	21,859.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,418.00	5,176.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	347.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	159,302.07	95,465.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,302.07	95,465.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,211,257.70	ADJUSTMENTS	78.32
COVERED CHARGES	2,151,701.44	CONTRACTUAL ALLOW	2,112,933.04
NON-COVERD CHARGES	59,556.26	TOTAL MEDICAID LIAB	38,768.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	38,768.40

TOTAL NUMBER OF CLAIMS 495

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,270.04	0.01
MED/SURG SUPPLY	12,264.00	63.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140,937.00	1,663.75
CT SCAN	262,723.50	27,095.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	29,241.00	1,194.50
IV THERAPY	163,169.75	0.00
OPERATING ROOM	18,016.25	20,503.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,198.00	0.00
ANESTHESIA	28,014.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,208,175.75	2,128.75
RECOVERY ROOM	2,268.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	25,711.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,862.00	4,609.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,619.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	235,502.40	2,298.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,728.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,151,701.44	59,556.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,151,701.44	59,556.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,871.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,284.25	CONTRACTUAL ALLOW	38,814.33
NON-COVERD CHARGES	8,586.75	TOTAL MEDICAID LIAB	469.92
		LESS: COB	469.92
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.50	0.00
MED/SURG SUPPLY	18.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,220.50	0.00
CT SCAN	8,687.75	7,700.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,284.25	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,296.00	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 SERVICE	1,397.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	882.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,113.25	324.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,255.50	562.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	39,284.25	8,586.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,284.25	8,586.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,076,417.89	ADJUSTMENTS	5,459.15
COVERED CHARGES	974,214.89	CONTRACTUAL ALLOW	914,167.12
NON-COVERD CHARGES	102,203.00	TOTAL MEDICAID LIAB	60,047.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	60,047.77

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,680.64	0.00
MED/SURG SUPPLY	87,572.25	1,767.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,685.25	0.00
CT SCAN	2,007.00	0.00
PHYSICAL THERAPY	0.00	13,330.25
EKG/ECG	5,972.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	312,127.50	39,113.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,588.50	0.00
ANESTHESIA	177,001.25	12,451.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,632.50	0.00
RECOVERY ROOM	21,052.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,337.50
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,282.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,966.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	115,783.75	6,652.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,700.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,607.00	1,119.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	165,555.50	23,432.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	974,214.89	102,203.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	974,214.89	102,203.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,057,152.14	ADJUSTMENTS	94,274.50
COVERED CHARGES	2,045,668.14	CONTRACTUAL ALLOW	1,429,531.67
NON-COVERD CHARGES	11,484.00	TOTAL MEDICAID LIAB	616,136.47
		LESS: COB	29,535.07
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	17,189.00
		REIMBURSEMENT	603,790.40

TOTAL NUMBER OF ADMISSIONS 103

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	234	0	250,614.00	0.00
ROUTINE NURSERY	43	0	24,080.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	277	0	274,694.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	69	0	90,390.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	69	0	90,390.00	0.00
TOTAL ACCOMODATIONS	346	0	365,084.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,254.65	0.00
MED/SURG SUPPLY	132,362.00	0.00
LABORATORY-GENERAL	359,217.00	0.00
RADIOLOGY-DIAGNOSTIC	21,445.00	0.00
CT SCAN	136,147.00	0.00
PHYSICAL THERAPY	5,706.00	0.00
EKG/ECG	28,920.00	0.00
IV THERAPY	64,860.00	0.00
OPERATING ROOM	123,545.00	0.00
LABOR/DELIVERY ROOM	166,430.00	0.00
RESPIRATORY SERVICES	74,858.00	0.00
ANESTHESIA	1,064.65	0.00
GI SERVICES	24,979.00	0.00
EMERGENCY ROOM	132,411.00	0.00
RECOVERY ROOM	20,518.00	0.00
LABORATORY PATHOLOGIC	4,350.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,508.00	0.00
SPEECH PATHOLOGY	1,666.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	616.39	2,594.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,195.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,174.00	6,240.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,492.00	0.00
AUDIOLOGY	6,371.00	0.00
CARDIOLOGY	43,145.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	27,265.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,335.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	800.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	16,908.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	88,624.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,217.00	1,850.00

TOTAL ANCILLARY	1,680,584.14	11,484.00
TOTAL ACCOMODATIONS	365,084.00	0.00
TOTAL CHARGES	2,045,668.14	11,484.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022313092499	10/27/22 - 11/03/22	11/14/22	1,217.00	0.00	0.00	0.00	0.00
-1	2323094000251	02/17/23 - 02/21/23	04/10/23	0.00	1,850.00	0.00	1,260.23	0.00
TOTAL				1,217.00	1,850.00	0.00	1,260.23	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,711.20	ADJUSTMENTS	0.00
COVERED CHARGES	15,931.20	CONTRACTUAL ALLOW	10,584.44
NON-COVERD CHARGES	780.00	TOTAL MEDICAID LIAB	5,346.76
		LESS: COB	5,346.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	2,142.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	2,142.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	2,142.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,423.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	147.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,299.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	525.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	765.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,094.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	376.00	780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,492.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,789.20	780.00
TOTAL ACCOMODATIONS	2,142.00	0.00
TOTAL CHARGES	15,931.20	780.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,073,664.77	ADJUSTMENTS	308,766.68
COVERED CHARGES	3,934,100.37	CONTRACTUAL ALLOW	3,073,565.44
NON-COVERD CHARGES	139,564.40	TOTAL MEDICAID LIAB	860,534.93
		LESS: COB	2,685.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	857,849.90
		ALL OTHER	743,385.16
		FEE SCHEDULE-LAB	108,886.50
		INJECTABLE DRUGS	5,578.24

TOTAL NUMBER OF CLAIMS 2,210

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,039.23	193.65
MED/SURG SUPPLY	103,176.00	691.00
LABORATORY-GENERAL	0.00	25.00
RADIOLOGY-DIAGNOSTIC	143,423.00	726.00
CT SCAN	415,975.00	21,355.00
PHYSICAL THERAPY	47,974.00	1,425.00
EKG/ECG	77,168.00	1,530.00
IV THERAPY	185,852.00	1,101.00
OPERATING ROOM	162,090.00	5,254.00
LABOR/DELIVERY ROOM	5,225.00	0.00
RESPIRATORY SERVICES	20,153.00	4,122.00
ANESTHESIA	2,530.95	0.00
GI SERVICES	126,644.50	12,844.50
EMERGENCY ROOM	1,023,639.00	8,273.00
RECOVERY ROOM	46,387.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	14,864.00	0.00
SPEECH PATHOLOGY	2,364.00	334.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	35,787.00	1,773.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	54,427.00	1,376.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,274.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,541.00	0.00
AUDIOLOGY	277.00	0.00
CARDIOLOGY	34,811.00	7,460.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	181,127.00	12,104.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,306.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,012,297.00	55,582.00
MRI SERVICES	48,580.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,246.69	835.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	106.00	250.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	32,816.00	2,310.00

TOTAL ANCILLARY	3,934,100.37	139,564.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,934,100.37	139,564.40

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	5922110000863	04/02/22 - 04/02/22	04/25/22	1,217.00	0.00	0.00	0.00	294.23
614	2222117007018	04/05/22 - 04/05/22	05/02/22	1,844.00	0.00	0.00	0.00	445.83
614	2022210078161	07/12/22 - 07/12/22	08/08/22	1,460.00	0.00	0.00	0.00	352.99
614	2222234007359	07/22/22 - 07/22/22	08/29/22	2,646.00	0.00	0.00	0.00	639.73
614	2022264083820	09/09/22 - 09/09/22	09/26/22	1,844.00	0.00	0.00	0.00	491.22
614	2022319074430	11/09/22 - 11/09/22	11/21/22	2,034.00	0.00	0.00	0.00	541.83
614	5922325000681	10/04/22 - 10/04/22	11/28/22	4,154.00	0.00	0.00	0.00	1,106.57
614	2022327096881	11/15/22 - 11/15/22	11/28/22	1,460.00	0.00	0.00	0.00	388.93
614	2022332047632	11/21/22 - 11/21/22	12/05/22	1,844.00	0.00	0.00	0.00	491.22
614	2022342105297	11/28/22 - 11/28/22	12/12/22	1,460.00	0.00	0.00	0.00	388.93
614	2222363009114	12/02/22 - 12/02/22	01/02/23	1,844.00	0.00	0.00	0.00	491.22
614	2023023044975	01/16/23 - 01/16/23	01/30/23	5,292.00	0.00	0.00	0.00	1,409.72
614	2023038058145	01/26/23 - 01/26/23	02/13/23	2,797.00	0.00	0.00	0.00	745.09
614	2023067101517	10/04/22 - 10/04/22	03/13/23	0.00	2,310.00	0.00	0.00	0.00
614	2023074080911	03/07/23 - 03/07/23	03/20/23	1,460.00	0.00	0.00	0.00	388.93
614	2023080027808	03/13/23 - 03/13/23	03/27/23	1,460.00	0.00	0.00	0.00	388.93
TOTAL				32,816.00	2,310.00	0.00	0.00	8,565.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,715.50	ADJUSTMENTS	0.00
COVERED CHARGES	35,863.50	CONTRACTUAL ALLOW	28,105.45
NON-COVERD CHARGES	15,852.00	TOTAL MEDICAID LIAB	7,758.05
		LESS: COB	7,758.05
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,470.00	0.00
MED/SURG SUPPLY	1,218.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639.00	0.00
CT SCAN	2,190.00	9,138.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	981.00	0.00
IV THERAPY	1,683.00	0.00
OPERATING ROOM	0.00	5,500.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	368.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,823.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	890.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	397.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,777.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,396.00	964.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	250.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,863.50	15,852.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,863.50	15,852.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	714,350.21	ADJUSTMENTS	3,759.36
COVERED CHARGES	708,513.76	CONTRACTUAL ALLOW	685,879.28
NON-COVERD CHARGES	5,836.45	TOTAL MEDICAID LIAB	22,634.48
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	22,634.48

TOTAL NUMBER OF CLAIMS 289

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,445.20	75.00
MED/SURG SUPPLY	9,791.00	75.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,698.00	0.00
CT SCAN	165,165.00	2,100.00
PHYSICAL THERAPY	196.00	0.00
EKG/ECG	12,352.00	327.00
IV THERAPY	29,581.00	509.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	586.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	364,413.00	190.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	112.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,250.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,036.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,918.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	93,226.00	2,286.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	856.56	162.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	708,513.76	5,836.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	708,513.76	5,836.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,815.60	ADJUSTMENTS	0.00
COVERED CHARGES	8,795.60	CONTRACTUAL ALLOW	8,638.96
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	563.60	0.00	OTHER LAB	779.00	0.00
MED/SURG SUPPLY	185.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,190.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	337.00	20.00
EKG/ECG	327.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	443.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,551.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,795.60	20.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,795.60	20.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	197,239.21	ADJUSTMENTS	37,740.29
COVERED CHARGES	194,018.21	CONTRACTUAL ALLOW	150,886.45
NON-COVERD CHARGES	3,221.00	TOTAL MEDICAID LIAB	43,131.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	43,131.76

TOTAL NUMBER OF CLAIMS 8

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,998.03	0.00
MED/SURG SUPPLY	18,448.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,998.00	1,189.00
CT SCAN	11,997.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,962.00	219.00
IV THERAPY	18,320.00	0.00
OPERATING ROOM	53,392.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19.00	0.00
ANESTHESIA	890.65	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,303.00	0.00
RECOVERY ROOM	10,546.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	338.00	1,624.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,463.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,850.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,908.00	189.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,585.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	194,018.21	3,221.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,018.21	3,221.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	173,240,622.39	ADJUSTMENTS	3,387,541.92
COVERED CHARGES	169,963,689.95	CONTRACTUAL ALLOW	143,849,988.79
NON-COVERD CHARGES	3,276,932.44	TOTAL MEDICAID LIAB	26,113,701.16
		LESS: COB	99,923.07
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	11,655.00
		REIMBURSEMENT	26,025,433.09

TOTAL NUMBER OF ADMISSIONS 2,194

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,477	0	19,157,521.00	0.00
ROUTINE NURSERY	2,685	0	12,779,335.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11,162	0	31,936,856.00	0.00
SPECIAL CARE SERVICES				
CCU	114	0	774,705.00	0.00
ICU	2,515	0	12,072,882.00	0.00
NICU	279	0	2,297,315.00	0.00
PED ICU	495	0	4,442,885.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	373	0	2,935,338.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,776	0	22,523,125.00	0.00
TOTAL ACCOMODATIONS	14,938	0	54,459,981.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,987,322.28	246.70
MED/SURG SUPPLY	11,919,898.76	325.00
LABORATORY-GENERAL	16,295,018.33	3,663.49
RADIOLOGY-DIAGNOSTIC	3,301,193.10	545.60
CT SCAN	4,665,887.97	1,452,371.06
PHYSICAL THERAPY	1,612,246.65	0.00
EKG/ECG	569,792.04	0.00
IV THERAPY	1,003,488.33	0.00
OPERATING ROOM	17,142,669.62	681,597.30
LABOR/DELIVERY ROOM	907,985.18	0.00
RESPIRATORY SERVICES	5,981,555.83	0.00
ANESTHESIA	4,754,157.50	0.00
GI SERVICES	469,057.51	0.00
EMERGENCY ROOM	8,100,338.60	6,482.00
RECOVERY ROOM	1,659,890.50	0.00
LABORATORY PATHOLOGIC	347,963.58	0.00
RADIOLOGY THERAPEUTIC	289,894.85	0.00
OCCUPATIONAL THERAPY	1,099,717.82	0.00
SPEECH PATHOLOGY	656,664.95	0.00
RENAL DIALYSIS	636,025.12	11,980.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	31,945.20	1,220.24
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	776,188.57	0.26
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,015,811.10	256,346.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	377,987.84	6,342.48
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,499,652.16	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	200,517.51	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	523,590.49	1,909.68

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	756,621.72	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,957,731.32	0.03
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,188,025.84	1,902.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	852,000.00
IMPL DEV CHARGE PATIENTS	5,774,868.68	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	115,503,708.95	3,276,932.44
TOTAL ACCOMODATIONS	54,459,981.00	0.00
TOTAL CHARGES	169,963,689.95	3,276,932.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	829,766.43	ADJUSTMENTS	0.00
COVERED CHARGES	822,951.42	CONTRACTUAL ALLOW	706,286.37
NON-COVERD CHARGES	6,815.01	TOTAL MEDICAID LIAB	116,665.05
		LESS: COB	116,791.05
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	126.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	33	0	85,027.00	0.00
ROUTINE NURSERY	32	0	123,014.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	65	0	208,041.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	15	0	71,831.00	0.00
NICU	0	0	0.00	0.00
PED ICU	2	0	17,294.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	89,125.00	0.00
TOTAL ACCOMODATIONS	82	0	297,166.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,393.71	0.00	OTHER LAB	3,023.00	0.00
MED/SURG SUPPLY	64,854.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	63,590.51	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,032.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,979.68	6,815.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,378.96	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,464.44	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,945.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	116,978.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,240.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,943.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,752.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,589.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,536.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,133.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	608.00	0.00	INJECTABLE DRUGS	47,918.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,219.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,987.69	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	209.28	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,143.25	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.01	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,198.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,348.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,264.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,053.52	0.00			

TOTAL ANCILLARY	525,785.42	6,815.01
TOTAL ACCOMODATIONS	297,166.00	0.00
TOTAL CHARGES	822,951.42	6,815.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,128,832.55	ADJUSTMENTS	614,867.12
COVERED CHARGES	37,650,462.96	CONTRACTUAL ALLOW	34,330,981.67
NON-COVERD CHARGES	5,478,369.59	TOTAL MEDICAID LIAB	3,319,481.29
		LESS: COB	10,347.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,309,134.10
		ALL OTHER	2,916,667.81
		FEE SCHEDULE-LAB	302,716.56
		INJECTABLE DRUGS	89,749.73

TOTAL NUMBER OF CLAIMS 7,213

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	316,409.45	90,267.19
MED/SURG SUPPLY	1,159,401.60	118,269.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,842,357.54	70,541.90
CT SCAN	2,630,640.86	684,630.98
PHYSICAL THERAPY	153,647.38	77,206.99
EKG/ECG	327,081.10	1,492.54
IV THERAPY	1,128,185.65	608.00
OPERATING ROOM	3,965,814.48	946,202.37
LABOR/DELIVERY ROOM	72,740.16	4,702.00
RESPIRATORY SERVICES	138,189.95	0.00
ANESTHESIA	2,037,180.90	0.00
GI SERVICES	268,917.41	117,792.09
EMERGENCY ROOM	12,883,616.40	22,154.88
RECOVERY ROOM	1,169,792.97	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,074,733.25	95,425.14
OCCUPATIONAL THERAPY	27,936.61	56,935.54
SPEECH PATHOLOGY	5,370.00	28,729.57
RENAL DIALYSIS	0.00	142,897.96
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	46,928.44	3,673.48
PSYCHIATRIC SERVICES	10,248.18	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	976,236.48	112,969.82
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	86,476.41	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	203,463.68	374,805.52
AUDIOLOGY	0.00	0.00
CARDIOLOGY	212,912.78	161,902.08
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,679.52	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	429,885.33	16,653.89

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	656,417.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,310.12
OTHER THERAPEUTIC SVC	0.00	1,923.48
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,434,288.68	137,510.91
MRI SERVICES	1,162,890.82	228,553.58
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	804,829.23	1,377,226.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	400,000.00
IMPL DEV CHARGE PATIENTS	417,190.50	203,983.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	37,650,462.96	5,478,369.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,650,462.96	5,478,369.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,779,909.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,095,053.80	CONTRACTUAL ALLOW	1,000,972.78
NON-COVERD CHARGES	684,855.50	TOTAL MEDICAID LIAB	94,081.02
		LESS: COB	94,081.02
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 239

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,547.57	1,527.94
MED/SURG SUPPLY	65,649.35	74,792.15
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,308.90	0.00
CT SCAN	14,946.08	60,431.95
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,226.76	0.00
IV THERAPY	18,613.76	0.00
OPERATING ROOM	59,834.35	208,601.35
LABOR/DELIVERY ROOM	1,334.16	0.00
RESPIRATORY SERVICES	4,597.10	0.00
ANESTHESIA	143,525.70	0.00
GI SERVICES	12,243.20	23,046.96
EMERGENCY ROOM	358,810.32	0.00
RECOVERY ROOM	66,863.07	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	98,922.64	96,494.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	3,797.56
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	515.32	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,989.96	19,911.21
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	14,100.48
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,479.28	116,380.74
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,733.78	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,177.11	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	113,439.39	13,017.82
MRI SERVICES	0.00	52,714.34
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	225.00	39.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,071.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,095,053.80	684,855.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,095,053.80	684,855.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	756,758.48	ADJUSTMENTS	134.26
COVERED CHARGES	750,710.85	CONTRACTUAL ALLOW	732,518.62
NON-COVERD CHARGES	6,047.63	TOTAL MEDICAID LIAB	18,192.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	18,192.23

TOTAL NUMBER OF CLAIMS 271

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,281.26	128.00
MED/SURG SUPPLY	1,745.80	1,414.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,061.90	1,118.00
CT SCAN	24,839.04	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,591.66	0.00
IV THERAPY	12,875.43	0.00
OPERATING ROOM	19,859.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	526.80	0.00
ANESTHESIA	12,441.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	584,728.40	1,330.56
RECOVERY ROOM	8,818.99	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,394.88	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,094.69	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	45,693.50	1,061.07
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	758.00	996.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	750,710.85	6,047.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	750,710.85	6,047.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,776.21	ADJUSTMENTS	0.00
COVERED CHARGES	43,585.21	CONTRACTUAL ALLOW	42,779.65
NON-COVERD CHARGES	5,191.00	TOTAL MEDICAID LIAB	805.56
		LESS: COB	805.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376.70	82.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,457.80	0.00
CT SCAN	0.00	5,109.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,335.25	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,586.40	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,829.06	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	43,585.21	5,191.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,585.21	5,191.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,335,893.67	ADJUSTMENTS	76,053.45
COVERED CHARGES	8,218,368.00	CONTRACTUAL ALLOW	7,826,694.19
NON-COVERD CHARGES	1,117,525.67	TOTAL MEDICAID LIAB	391,673.81
		LESS: COB	352.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	391,321.49

TOTAL NUMBER OF CLAIMS 63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,626.53	10,448.54
MED/SURG SUPPLY	1,017,943.50	162,139.40
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,736.00	1,856.60
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	9,782.56
EKG/ECG	3,542.76	0.00
IV THERAPY	1,311.27	0.00
OPERATING ROOM	1,508,678.35	87,876.95
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	331,848.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	824.00	0.00
RECOVERY ROOM	155,460.09	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,179,957.46	8,490.01
OCCUPATIONAL THERAPY	0.00	2,869.26
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,188.10	16,346.73
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	473,074.48
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	10,177.45	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	28,860.59	813.14
MRI SERVICES	0.00	6,631.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	371,500.00	7,960.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,555,713.00	329,237.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,218,368.00	1,117,525.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,218,368.00	1,117,525.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,587,413.21	ADJUSTMENTS	0.00
COVERED CHARGES	2,570,124.49	CONTRACTUAL ALLOW	2,483,304.89
NON-COVERD CHARGES	17,288.72	TOTAL MEDICAID LIAB	86,819.60
		LESS: COB	86,819.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,350,190.02	74.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,169.25	40.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,897.52	270.32
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,074.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	762.30	16,903.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,069.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,479.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	7,063.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	193,418.75	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,570,124.49	17,288.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,570,124.49	17,288.72

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,538,663.99	ADJUSTMENTS	11,764.10
COVERED CHARGES	2,526,459.34	CONTRACTUAL ALLOW	1,416,824.03
NON-COVERD CHARGES	12,204.65	TOTAL MEDICAID LIAB	1,109,635.31
		LESS: COB	18,723.92
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,090,911.39

TOTAL NUMBER OF ADMISSIONS 92

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	401	0	387,840.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	401	0	387,840.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	401	0	387,840.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	998,736.51	0.00	OTHER LAB	6,675.00	0.00
MED/SURG SUPPLY	103,468.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	304,887.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,259.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	88,138.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	845.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,540.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,585.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	206,530.00	3,844.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	138,935.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,536.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	20,355.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21.93	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	3,355.00	0.00	NO CC/INVALID REV CODE	0.00	1,400.00
BLOOD	2,856.00	0.00			
BLOOD STORAGE & PRO.	47,208.00	6,960.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,038.00	0.00			

TOTAL ANCILLARY	2,138,619.34	12,204.65
TOTAL ACCOMODATIONS	387,840.00	0.00
TOTAL CHARGES	2,526,459.34	12,204.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2324052000146	06/28/23 - 07/02/23	02/26/24	0.00	1,400.00	0.00	2,033.37	0.00
TOTAL				0.00	1,400.00	0.00	2,033.37	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,137.35	ADJUSTMENTS	0.00
COVERED CHARGES	57,137.35	CONTRACTUAL ALLOW	45,975.35
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	11,162.00
		LESS: COB	11,162.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	7	0	6,720.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	6,720.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	6,720.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,433.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,569.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,754.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	152.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,536.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	698.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	579.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,505.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	50,417.35	0.00
TOTAL ACCOMODATIONS	6,720.00	0.00
TOTAL CHARGES	57,137.35	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,782,037.35	ADJUSTMENTS	78,739.01
COVERED CHARGES	6,911,613.02	CONTRACTUAL ALLOW	4,650,907.24
NON-COVERD CHARGES	1,870,424.33	TOTAL MEDICAID LIAB	2,260,705.78
		LESS: COB	2,871.41
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,257,834.37
		ALL OTHER	1,884,767.39
		FEE SCHEDULE-LAB	373,052.02
		INJECTABLE DRUGS	14.96

TOTAL NUMBER OF CLAIMS 10,731

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	527,836.87	721.20
MED/SURG SUPPLY	231,047.65	23,165.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	365,723.00	3,220.00
CT SCAN	179,304.00	13,821.00
PHYSICAL THERAPY	3,354.00	0.00
EKG/ECG	15,696.00	1,744.00
IV THERAPY	20,232.00	1,976.00
OPERATING ROOM	1,881,740.00	1,457,986.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	119,737.00	7,964.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	208,364.00	12,279.00
RECOVERY ROOM	183,500.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	250.00	0.00
SPEECH PATHOLOGY	2,198.00	628.00
RENAL DIALYSIS	0.00	2,550.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,670.00	1,187.93
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	37,546.00	1,297.00
BLOOD	4,760.00	0.00
BLOOD STORAGE & PRO.	214,372.00	9,364.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	22,400.00	3,896.00
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/OBSERV. RM	622,624.00	57,367.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	87,989.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,174,336.10	269,744.00
MRI SERVICES	2,178.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,005.40	1,513.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,911,613.02	1,870,424.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,911,613.02	1,870,424.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,010.60	ADJUSTMENTS	0.00
COVERED CHARGES	17,540.60	CONTRACTUAL ALLOW	11,659.29
NON-COVERD CHARGES	3,470.00	TOTAL MEDICAID LIAB	5,881.31
		LESS: COB	5,881.31
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	954.95	0.00
MED/SURG SUPPLY	773.65	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,405.00	580.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	109.00	0.00
IV THERAPY	422.00	0.00
OPERATING ROOM	4,025.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	55.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,575.00	162.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,010.00	1,856.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	988.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,278.00	817.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,540.60	3,470.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,540.60	3,470.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,628.36	ADJUSTMENTS	140.00
COVERED CHARGES	80,639.36	CONTRACTUAL ALLOW	77,349.36
NON-COVERD CHARGES	2,989.00	TOTAL MEDICAID LIAB	3,290.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,290.00

TOTAL NUMBER OF CLAIMS 47

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,062.66	5.00
MED/SURG SUPPLY	497.70	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,506.00	0.00
CT SCAN	32,992.00	1,401.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	327.00	0.00
IV THERAPY	983.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	55.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,749.00	176.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	458.00	0.00
BLOOD	476.00	0.00
BLOOD STORAGE & PRO.	1,493.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,441.00	301.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,599.00	1,106.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	80,639.36	2,989.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,639.36	2,989.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	919.00	ADJUSTMENTS	0.00
COVERED CHARGES	919.00	CONTRACTUAL ALLOW	849.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	919.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	919.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	919.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,579,333.10	ADJUSTMENTS	46,432.62
COVERED CHARGES	1,567,990.10	CONTRACTUAL ALLOW	1,227,486.68
NON-COVERD CHARGES	11,343.00	TOTAL MEDICAID LIAB	340,503.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	340,503.42

TOTAL NUMBER OF CLAIMS 66

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,432.30	0.00
MED/SURG SUPPLY	11,948.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,434.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	304.00	0.00
OPERATING ROOM	1,460,669.00	7,346.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	91.00	351.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,518.00	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	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,981.00	928.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,186.00	960.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,926.00	1,758.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,567,990.10	11,343.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,567,990.10	11,343.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	113,534.00	ADJUSTMENTS	0.00
COVERED CHARGES	113,534.00	CONTRACTUAL ALLOW	70,746.41
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	42,787.59
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	42,787.59

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	16	0	15,607.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16	0	15,607.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	16	0	15,607.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,249.00	0.00	OTHER LAB	512.00	0.00
MED/SURG SUPPLY	3,636.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,336.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,436.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,189.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,844.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,070.00	0.00	MRI SERVICES	5,155.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,953.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,793.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,605.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	493.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,032.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,008.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,616.00	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/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	97,927.00	0.00
TOTAL ACCOMODATIONS	15,607.00	0.00
TOTAL CHARGES	113,534.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,535,020.00	ADJUSTMENTS	27,496.19
COVERED CHARGES	2,388,041.00	CONTRACTUAL ALLOW	1,965,401.11
NON-COVERD CHARGES	146,979.00	TOTAL MEDICAID LIAB	422,639.89
		LESS: COB	527.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	422,112.68
		ALL OTHER	338,910.35
		FEE SCHEDULE-LAB	79,374.04
		INJECTABLE DRUGS	3,828.29

TOTAL NUMBER OF CLAIMS 1,968

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,844.00	1,262.00
MED/SURG SUPPLY	19,076.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,711.00	1,793.00
CT SCAN	419,877.00	70,852.00
PHYSICAL THERAPY	60,734.00	4,723.00
EKG/ECG	29,210.00	0.00
IV THERAPY	153,121.00	3,082.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,940.00	2,537.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	556,544.00	1,037.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,259.00	798.00
SPEECH PATHOLOGY	1,023.00	720.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	640.00	284.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	50,106.00	983.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,428.00	504.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	22,464.00	2,808.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,088.00	5,210.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,258.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	674,947.00	42,708.00
MRI SERVICES	56,764.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,007.00	7,678.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,388,041.00	146,979.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,388,041.00	146,979.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,756.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,720.00	CONTRACTUAL ALLOW	5,512.94
NON-COVERD CHARGES	36.00	TOTAL MEDICAID LIAB	1,207.06
		LESS: COB	1,207.06
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.00	36.00	OTHER LAB	957.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,096.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	102.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,645.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	619.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,720.00	36.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,720.00	36.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,502.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,263.00	CONTRACTUAL ALLOW	37,113.00
NON-COVERD CHARGES	239.00	TOTAL MEDICAID LIAB	3,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,150.00

TOTAL NUMBER OF CLAIMS 45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107.00	122.00
MED/SURG SUPPLY	132.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,448.00	0.00
CT SCAN	3,808.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,989.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,800.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,100.00	105.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,879.00	12.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	40,263.00	239.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,263.00	239.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,835.85	ADJUSTMENTS	0.00
COVERED CHARGES	160,729.87	CONTRACTUAL ALLOW	77,301.53
NON-COVERD CHARGES	5,105.98	TOTAL MEDICAID LIAB	83,428.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	83,428.34

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	47	0	21,855.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	21,855.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	4,540.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,540.00	0.00
TOTAL ACCOMODATIONS	52	0	26,395.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,989.11	992.50
MED/SURG SUPPLY	5,866.08	0.00
LABORATORY-GENERAL	29,325.43	2,164.66
RADIOLOGY-DIAGNOSTIC	3,053.75	0.00
CT SCAN	13,696.71	0.00
PHYSICAL THERAPY	1,384.26	0.00
EKG/ECG	8,864.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,782.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,816.78	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,454.00	1,948.82
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,600.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,502.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	134,334.87	5,105.98
TOTAL ACCOMODATIONS	26,395.00	0.00
TOTAL CHARGES	160,729.87	5,105.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	849,027.38	ADJUSTMENTS	2,317.63
COVERED CHARGES	660,564.09	CONTRACTUAL ALLOW	467,519.39
NON-COVERD CHARGES	188,463.29	TOTAL MEDICAID LIAB	193,044.70
		LESS: COB	335.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	192,709.37
		ALL OTHER	167,173.41
		FEE SCHEDULE-LAB	25,217.22
		INJECTABLE DRUGS	318.74

TOTAL NUMBER OF CLAIMS 454

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,249.48	12,359.98
MED/SURG SUPPLY	8,698.11	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,311.21	1,119.21
CT SCAN	56,216.26	116,665.64
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,256.90	722.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,158.65	2,428.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	351,622.14	24,519.80
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	1,173.24	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	13,882.27	864.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,094.00	1,454.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,000.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,753.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	140,971.83	17,597.66
MRI SERVICES	15,000.00	4,000.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,177.00	6,733.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	660,564.09	188,463.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	660,564.09	188,463.29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,307.90	ADJUSTMENTS	0.00
COVERED CHARGES	4,999.90	CONTRACTUAL ALLOW	3,574.94
NON-COVERD CHARGES	5,308.00	TOTAL MEDICAID LIAB	1,424.96
		LESS: COB	1,424.96
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	195.00
MED/SURG SUPPLY	151.90	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	155.00	0.00
CT SCAN	1,261.00	2,690.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	118.00	118.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,427.00	1,511.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	812.00	624.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	50.00	170.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,999.90	5,308.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,999.90	5,308.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	168,347.18	ADJUSTMENTS	70.00
COVERED CHARGES	138,259.58	CONTRACTUAL ALLOW	130,844.54
NON-COVERD CHARGES	30,087.60	TOTAL MEDICAID LIAB	7,415.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,415.04

TOTAL NUMBER OF CLAIMS 106

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,067.00	1,248.25
MED/SURG SUPPLY	2,320.44	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,728.86	527.00
CT SCAN	12,505.12	20,152.74
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,423.00	236.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	392.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	91,116.77	3,493.03
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,311.39	3,143.58
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,395.00	1,287.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	138,259.58	30,087.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	138,259.58	30,087.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,514,966.23	ADJUSTMENTS	19,309.03
COVERED CHARGES	2,512,032.43	CONTRACTUAL ALLOW	2,044,260.06
NON-COVERD CHARGES	2,933.80	TOTAL MEDICAID LIAB	467,772.37
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	467,772.37

TOTAL NUMBER OF ADMISSIONS 56

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	132	0	297,048.54	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	132	0	297,048.54	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	37	0	96,348.24	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	37	0	96,348.24	0.00
TOTAL ACCOMODATIONS	169	0	393,396.78	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,882.98	0.00
MED/SURG SUPPLY	1,443.94	0.00
LABORATORY-GENERAL	522,283.14	0.00
RADIOLOGY-DIAGNOSTIC	49,539.64	0.00
CT SCAN	189,635.79	0.00
PHYSICAL THERAPY	14,064.13	0.00
EKG/ECG	59,380.95	0.00
IV THERAPY	46,888.66	0.00
OPERATING ROOM	5,422.63	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	344,275.51	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	191,464.84	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	2,429.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,014.63	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	244.96	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,607.04	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	559.16	2,933.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	127,204.56	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	27,816.83	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	20,369.46	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	361,951.53	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	13,155.61	0.00

TOTAL ANCILLARY	2,118,635.65	2,933.80
TOTAL ACCOMODATIONS	393,396.78	0.00
TOTAL CHARGES	2,512,032.43	2,933.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2223125013257	04/13/23 - 04/17/23	05/08/23	7,389.78	0.00	0.00	0.00	0.00
614	5924026001547	12/09/23 - 12/10/23	02/05/24	5,765.83	0.00	0.00	0.00	0.00
TOTAL				13,155.61	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,082,685.27	ADJUSTMENTS	155,462.30
COVERED CHARGES	9,098,397.91	CONTRACTUAL ALLOW	8,236,720.95
NON-COVERD CHARGES	984,287.36	TOTAL MEDICAID LIAB	861,676.96
		LESS: COB	2,752.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	858,924.52
		ALL OTHER	740,704.63
		FEE SCHEDULE-LAB	111,561.40
		INJECTABLE DRUGS	6,658.49

TOTAL NUMBER OF CLAIMS 2,110

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,257.49	31,916.54
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	377,039.01	15,774.26
CT SCAN	1,097,428.39	453,105.82
PHYSICAL THERAPY	938,300.00	61,699.91
EKG/ECG	220,258.35	11,049.75
IV THERAPY	812,946.91	53,741.69
OPERATING ROOM	166,168.89	23,250.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	46,492.11	12,590.07
ANESTHESIA	57,789.24	0.00
GI SERVICES	0.00	3,205.00
EMERGENCY ROOM	2,418,295.27	22,326.91
RECOVERY ROOM	72,290.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,429.41	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	22,069.46	0.00
CLINIC SERVICES	857.36	1,714.72
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	52,696.48	10,545.86
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,966.53	3,414.14
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	17,405.96
AUDIOLOGY	0.00	0.00
CARDIOLOGY	32,349.64	23,534.68
AMBULATORY SURGERY	330.16	1,711.77
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	86,284.14	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	57,576.73	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,093,804.50	80,376.44
MRI SERVICES	128,942.79	4,456.51
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	206,488.92	142,752.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	98,336.13	9,714.25

TOTAL ANCILLARY	9,098,397.91	984,287.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,098,397.91	984,287.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023023032832	01/17/23 - 01/17/23	01/30/23	5,103.65	0.00	0.00	0.00	563.57
614	2023046066659	02/09/23 - 02/09/23	02/20/23	5,257.06	0.00	0.00	0.00	580.51
614	2023099004213	04/05/23 - 04/05/23	04/17/23	3,703.83	0.00	0.00	0.00	409.00
614	2023106002934	04/12/23 - 04/12/23	04/24/23	3,703.83	0.00	0.00	0.00	409.00
614	2023114029603	04/20/23 - 04/20/23	05/01/23	5,279.63	0.00	0.00	0.00	583.01
614	2023133033999	05/08/23 - 05/08/23	05/22/23	4,154.89	0.00	0.00	0.00	458.81
614	2223163008950	04/20/23 - 04/20/23	06/19/23	4,154.89	0.00	0.00	0.00	458.81
615	5923179000304	06/01/23 - 06/01/23	07/03/23	4,003.58	0.00	0.00	0.00	442.09
614	2023189037428	07/03/23 - 07/03/23	07/17/23	4,509.34	0.00	0.00	0.00	497.94
614	2023195070279	07/10/23 - 07/10/23	07/24/23	4,513.20	0.00	0.00	0.00	498.37
614	2023196028697	07/11/23 - 07/11/23	07/24/23	5,279.63	0.00	0.00	0.00	583.01
614	2023227049220	08/11/23 - 08/11/23	08/21/23	4,154.89	0.00	0.00	0.00	458.81
615	5923233000817	06/19/23 - 06/19/23	08/28/23	4,003.58	0.00	0.00	0.00	442.09
615	5923233000817	06/19/23 - 06/19/23	08/28/23	0.00	3,386.20	0.00	0.00	0.00
614	2023248047356	08/31/23 - 08/31/23	09/11/23	4,154.89	0.00	0.00	0.00	446.26
614	2023256059525	09/08/23 - 09/08/23	09/18/23	5,279.63	0.00	0.00	0.00	567.05
614	2023273028619	09/26/23 - 09/26/23	10/09/23	5,765.83	0.00	0.00	0.00	619.28
614	2023275033903	09/28/23 - 09/28/23	10/09/23	5,320.00	0.00	0.00	0.00	571.39
614	2023308029852	10/31/23 - 10/31/23	11/13/23	5,279.63	0.00	0.00	0.00	567.05
614	2023339056446	09/08/23 - 09/08/23	12/11/23	0.00	6,328.05	0.00	0.00	0.00
614	2023352003249	12/13/23 - 12/13/23	12/25/23	5,279.63	0.00	0.00	0.00	567.05
614	2023353058987	12/15/23 - 12/15/23	12/25/23	4,154.89	0.00	0.00	0.00	446.26
614	2024053083623	12/07/23 - 12/07/23	02/26/24	5,279.63	0.00	0.00	0.00	567.05
TOTAL				98,336.13	9,714.25	0.00	0.00	10,736.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,878.36	ADJUSTMENTS	0.00
COVERED CHARGES	24,864.65	CONTRACTUAL ALLOW	22,651.42
NON-COVERD CHARGES	2,013.71	TOTAL MEDICAID LIAB	2,213.23
		LESS: COB	2,213.23
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	507.82
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,149.69	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	4,721.86	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,042.98	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,558.39	548.48
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	391.73	957.41
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	24,864.65	2,013.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,864.65	2,013.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,179.92	ADJUSTMENTS	391.60
COVERED CHARGES	401,121.86	CONTRACTUAL ALLOW	389,922.10
NON-COVERD CHARGES	17,058.06	TOTAL MEDICAID LIAB	11,199.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	11,199.76

TOTAL NUMBER OF CLAIMS 143

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	476.46	95.70
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,839.41	297.64
CT SCAN	34,004.35	10,789.89
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,103.15	0.00
IV THERAPY	23,292.09	363.82
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,320.54	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	226,645.06	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	122.48
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,284.12	598.94
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,833.34	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	75,212.57	1,952.53
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,110.77	2,837.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	401,121.86	17,058.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	401,121.86	17,058.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	155,872.77	ADJUSTMENTS	0.00
COVERED CHARGES	149,277.25	CONTRACTUAL ALLOW	143,095.65
NON-COVERD CHARGES	6,595.52	TOTAL MEDICAID LIAB	6,181.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,181.60

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,390.33	100.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,024.38	2,471.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,416.57	0.00
EKG/ECG	736.65	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	3,365.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,258.46	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	136,450.86	658.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	149,277.25	6,595.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	149,277.25	6,595.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,697,279.05	ADJUSTMENTS	719,473.89
COVERED CHARGES	26,569,046.05	CONTRACTUAL ALLOW	22,627,434.83
NON-COVERD CHARGES	128,233.00	TOTAL MEDICAID LIAB	3,941,611.22
		LESS: COB	36,252.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,260.00
		REIMBURSEMENT	3,906,618.85

TOTAL NUMBER OF ADMISSIONS 430

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,402	0	2,558,204.00	0.00
ROUTINE NURSERY	115	0	236,780.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	32.00
TOTAL ROUTINE	1,517	0	2,794,984.00	32.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	543	0	2,868,253.00	0.00
NICU	1	0	6,271.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	544	0	2,874,524.00	0.00
TOTAL ACCOMODATIONS	2,061	0	5,669,508.00	32.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,230,396.07	0.00
MED/SURG SUPPLY	438,871.35	0.00
LABORATORY-GENERAL	5,299,105.00	0.00
RADIOLOGY-DIAGNOSTIC	341,429.00	0.00
CT SCAN	2,201,472.55	18,403.00
PHYSICAL THERAPY	168,856.00	0.00
EKG/ECG	346,802.00	0.00
IV THERAPY	619,157.00	0.00
OPERATING ROOM	1,533,298.00	0.00
LABOR/DELIVERY ROOM	153,672.00	0.00
RESPIRATORY SERVICES	1,992,109.00	0.00
ANESTHESIA	192,572.00	0.00
GI SERVICES	366,498.00	0.00
EMERGENCY ROOM	1,444,127.00	0.00
RECOVERY ROOM	252,669.00	0.00
LABORATORY PATHOLOGIC	89,480.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	33,312.00	0.00
RENAL DIALYSIS	1,003,474.00	5,606.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,537.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	152,893.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	203,445.00	67,350.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	149,049.02	30,222.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	458,831.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,837.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	200,423.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	162,175.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	536,499.14	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	6,620.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	272,548.67	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,899,538.05	128,201.00
TOTAL ACCOMODATIONS	5,669,508.00	32.00
TOTAL CHARGES	26,569,046.05	128,233.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	152,377.26	ADJUSTMENTS	0.00
COVERED CHARGES	152,377.26	CONTRACTUAL ALLOW	119,261.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	33,115.36
		LESS: COB	33,115.36
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	23,712.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	23,712.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	5,327.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	5,327.00	0.00
TOTAL ACCOMODATIONS	14	0	29,039.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,043.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,776.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,100.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,565.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,182.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,659.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,228.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,926.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,427.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,874.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,718.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,497.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,569.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,278.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,495.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	123,338.26	0.00
TOTAL ACCOMODATIONS	29,039.00	0.00
TOTAL CHARGES	152,377.26	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,663,234.58	ADJUSTMENTS	169,707.12
COVERED CHARGES	18,003,172.10	CONTRACTUAL ALLOW	16,131,864.36
NON-COVERD CHARGES	2,660,062.48	TOTAL MEDICAID LIAB	1,871,307.74
		LESS: COB	6,534.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,864,773.37
		ALL OTHER	1,631,707.99
		FEE SCHEDULE-LAB	172,040.01
		INJECTABLE DRUGS	61,025.37

TOTAL NUMBER OF CLAIMS 3,289

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261,414.26	1,664.00
MED/SURG SUPPLY	246,223.70	15,153.80
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	610,373.00	14,593.00
CT SCAN	3,268,973.00	559,933.04
PHYSICAL THERAPY	142,038.00	43,534.00
EKG/ECG	367,522.00	11,060.00
IV THERAPY	1,342,495.00	220,164.00
OPERATING ROOM	1,392,237.92	226,043.08
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	134,068.00	63,653.00
ANESTHESIA	222,283.00	0.00
GI SERVICES	207,401.00	130,091.00
EMERGENCY ROOM	4,175,935.00	2,141.00
RECOVERY ROOM	362,419.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	60,564.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,904.00	11,702.00
RENAL DIALYSIS	0.00	128,938.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	155.00	4,956.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	394,427.00	32,089.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	35,434.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	120,916.00	213,793.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	192,480.00	105,232.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,390.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	417,359.77	4,955.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	163,745.00	1,986.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,119,781.61	161,411.00
MRI SERVICES	282,906.00	257,124.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	457,667.04	391,552.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	11,059.80	58,294.40
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,003,172.10	2,660,062.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,003,172.10	2,660,062.48

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	266,297.32	ADJUSTMENTS	0.00
COVERED CHARGES	194,312.18	CONTRACTUAL ALLOW	174,339.98
NON-COVERD CHARGES	71,985.14	TOTAL MEDICAID LIAB	19,972.20
		LESS: COB	19,972.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 44

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,767.62	416.00
MED/SURG SUPPLY	6,263.57	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,245.00	592.00
CT SCAN	12,756.00	36,548.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,424.00	0.00
IV THERAPY	16,795.00	557.00
OPERATING ROOM	20,222.00	14,528.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	379.00	0.00
ANESTHESIA	3,356.00	0.00
GI SERVICES	3,941.00	3,941.00
EMERGENCY ROOM	54,343.00	0.00
RECOVERY ROOM	9,842.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,325.00	3,536.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,025.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	41,698.00	6,584.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	929.49	4,659.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	624.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	194,312.18	71,985.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,312.18	71,985.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,532,595.75	ADJUSTMENTS	402.78
COVERED CHARGES	1,488,050.90	CONTRACTUAL ALLOW	1,464,891.05
NON-COVERD CHARGES	44,544.85	TOTAL MEDICAID LIAB	23,159.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	23,159.85

TOTAL NUMBER OF CLAIMS 345

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,882.54	0.00
MED/SURG SUPPLY	236.39	744.43
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,755.00	1,863.00
CT SCAN	332,902.00	11,080.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	30,415.00	553.00
IV THERAPY	125,407.00	16,608.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	643.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	641,240.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	155.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,269.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,080.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	483.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	8,053.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	212,723.00	5,798.00
MRI SERVICES	24,273.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,688.97	7,743.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,488,050.90	44,544.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,488,050.90	44,544.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,236.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,532.40	CONTRACTUAL ALLOW	15,196.75
NON-COVERD CHARGES	703.60	TOTAL MEDICAID LIAB	335.65
		LESS: COB	335.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	374.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.00	553.00
IV THERAPY	1,114.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,844.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,611.00	135.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.40	15.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	15,532.40	703.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,532.40	703.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,439,152.02	ADJUSTMENTS	5,174.65
COVERED CHARGES	1,302,338.92	CONTRACTUAL ALLOW	1,214,370.71
NON-COVERD CHARGES	136,813.10	TOTAL MEDICAID LIAB	87,968.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	87,968.21

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,834.28	0.00
MED/SURG SUPPLY	27,504.12	1,231.45
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,270.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	2,659.00
EKG/ECG	0.00	0.00
IV THERAPY	9,373.00	0.00
OPERATING ROOM	225,947.00	44,128.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	922.00	0.00
ANESTHESIA	49,824.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	37,082.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,264.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,900.00	3,532.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	116,250.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,327.00	1,445.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	753,906.16	5,395.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	42,935.36	78,422.44
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,302,338.92	136,813.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,302,338.92	136,813.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	250,070,307.76	ADJUSTMENTS	14,198,402.35
COVERED CHARGES	249,237,874.26	CONTRACTUAL ALLOW	206,034,442.01
NON-COVERD CHARGES	832,433.50	TOTAL MEDICAID LIAB	43,203,432.25
		LESS: COB	397,318.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	848,000.00
		REIMBURSEMENT	43,654,114.24

TOTAL NUMBER OF ADMISSIONS 7,422

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14,293	0	25,723,491.00	0.00
ROUTINE NURSERY	12,803	0	33,494,385.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27,096	0	59,217,876.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,367	0	18,309,157.00	0.00
NICU	443	0	3,845,012.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,810	0	22,154,169.00	0.00
TOTAL ACCOMODATIONS	30,906	0	81,372,045.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,993,804.17	15,488.00
MED/SURG SUPPLY	2,980,392.71	1,214.00
LABORATORY-GENERAL	36,108,214.44	0.00
RADIOLOGY-DIAGNOSTIC	2,213,526.50	0.00
CT SCAN	5,208,393.00	0.00
PHYSICAL THERAPY	1,148,462.00	0.00
EKG/ECG	664,558.00	0.00
IV THERAPY	345,866.00	6,615.00
OPERATING ROOM	15,518,319.50	26,743.00
LABOR/DELIVERY ROOM	14,457,510.00	8,926.00
RESPIRATORY SERVICES	4,390,021.01	0.00
ANESTHESIA	2,304,750.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,357,039.00	0.00
RECOVERY ROOM	3,021,247.50	0.00
LABORATORY PATHOLOGIC	2,867,101.00	0.00
RADIOLOGY THERAPEUTIC	600,713.00	0.00
OCCUPATIONAL THERAPY	1,522,289.50	0.00
SPEECH PATHOLOGY	581,692.50	0.00
RENAL DIALYSIS	928,876.00	45,976.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	7,383.00
PSYCHIATRIC SERVICES	6,732.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,500,364.50	129,024.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,150,902.00	27,612.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	405,362.00	78,600.00
AUDIOLOGY	1,378,486.00	0.00
CARDIOLOGY	3,670,190.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	402,425.00	0.00
ORGAN ACQUISITION	69,370.00	0.00
TREATMENT/OBSERV. RM	182,350.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	697,941.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	19,366.00	0.00
OTHER THERAPEUTIC SVC	0.00	114,147.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,629,757.00	27,181.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	7,821.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	149,298.00
DRUG-SPECIFIC/HOME IV	0.00	159,462.50
INJECTABLE DRUGS	20,538,177.89	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,838,949.04	0.00
GENE THERAPY DRUGS	4,162,680.00	0.00
NO CC/INVALID REV CODE	0.00	26,943.00

TOTAL ANCILLARY	167,865,829.26	832,433.50
TOTAL ACCOMODATIONS	81,372,045.00	0.00
TOTAL CHARGES	249,237,874.26	832,433.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
873	9723037981054	11/11/22 - 11/12/22	02/13/23	0.00	5,322.00	0.00	0.00	0.00
874	9723037981054	11/11/22 - 11/12/22	02/13/23	0.00	2,984.00	0.00	0.00	0.00
871	9723100981062	10/12/22 - 11/08/22	04/17/23	0.00	10,331.00	0.00	0.00	0.00
873	9723100981062	10/12/22 - 11/08/22	04/17/23	0.00	5,322.00	0.00	0.00	0.00
874	9723100981062	10/12/22 - 11/08/22	04/17/23	0.00	2,984.00	0.00	0.00	0.00
-1	2323360000160	08/08/23 - 08/11/23	01/29/24	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	26,943.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,362,913.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,325,031.00	CONTRACTUAL ALLOW	3,811,531.24
NON-COVERD CHARGES	37,882.00	TOTAL MEDICAID LIAB	513,499.76
		LESS: COB	513,499.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 82

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	180	0	316,186.00	0.00
ROUTINE NURSERY	315	0	1,411,103.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	495	0	1,727,289.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	43	0	225,772.00	0.00
NICU	11	0	94,523.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	54	0	320,295.00	0.00
TOTAL ACCOMODATIONS	549	0	2,047,584.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356,342.00	0.00
MED/SURG SUPPLY	59,156.00	0.00
LABORATORY-GENERAL	442,714.00	0.00
RADIOLOGY-DIAGNOSTIC	51,799.00	0.00
CT SCAN	53,540.00	0.00
PHYSICAL THERAPY	4,416.00	0.00
EKG/ECG	6,552.00	0.00
IV THERAPY	678.00	0.00
OPERATING ROOM	286,298.00	0.00
LABOR/DELIVERY ROOM	227,087.00	0.00
RESPIRATORY SERVICES	192,130.00	0.00
ANESTHESIA	35,065.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,666.00	0.00
RECOVERY ROOM	57,892.00	0.00
LABORATORY PATHOLOGIC	12,956.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,942.00	0.00
SPEECH PATHOLOGY	3,940.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,756.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	20,996.00	6,903.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	17,821.00	0.00
CARDIOLOGY	42,400.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,823.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,062.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	318.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,616.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	27,363.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	226,597.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	100,501.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,277,447.00	37,882.00
TOTAL ACCOMODATIONS	2,047,584.00	0.00
TOTAL CHARGES	4,325,031.00	37,882.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,652,621.53	ADJUSTMENTS	1,740,972.50
COVERED CHARGES	44,612,899.43	CONTRACTUAL ALLOW	36,432,573.34
NON-COVERD CHARGES	8,039,722.10	TOTAL MEDICAID LIAB	8,180,326.09
		LESS: COB	10,620.35
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,169,705.74
		ALL OTHER	6,015,090.46
		FEE SCHEDULE-LAB	644,500.09
		INJECTABLE DRUGS	1,510,115.19

TOTAL NUMBER OF CLAIMS 9,350

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	853,582.08	100,063.81
MED/SURG SUPPLY	595,261.00	13,292.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	721,540.00	2,237.00
CT SCAN	4,245,788.00	652,530.00
PHYSICAL THERAPY	100,122.00	66,107.00
EKG/ECG	280,002.00	1,404.00
IV THERAPY	5,590,861.00	105,707.00
OPERATING ROOM	1,970,935.50	653,765.00
LABOR/DELIVERY ROOM	70,063.00	0.00
RESPIRATORY SERVICES	88,621.00	3,321.00
ANESTHESIA	527,219.00	0.00
GI SERVICES	50,213.00	0.00
EMERGENCY ROOM	3,643,435.00	14,685.00
RECOVERY ROOM	372,584.00	0.00
LABORATORY PATHOLOGIC	0.00	1,332.00
RADIOLOGY THERAPEUTIC	2,233,593.00	48,390.00
OCCUPATIONAL THERAPY	45,495.00	69,767.00
SPEECH PATHOLOGY	1,195.00	11,247.00
RENAL DIALYSIS	0.00	39,408.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,153,430.00	14,407.00
PSYCHIATRIC SERVICES	73,348.00	38,010.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,994,346.00	249,267.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	397,626.00	288,365.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,152.00	31,141.00
AUDIOLOGY	1,610.00	0.00
CARDIOLOGY	95,539.00	106,310.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,360.00	0.00
ORGAN ACQUISITION	0.00	250,702.45
TREATMENT/OBSERV. RM	927,136.19	570.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	173,139.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,394.00	318.00
OTHER THERAPEUTIC SVC	0.00	18,564.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,860,492.70	1,344,215.00
MRI SERVICES	2,412,774.00	156,058.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	497.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	600.00
DRUG-SPECIFIC/HOME IV	0.00	817.09
INJECTABLE DRUGS	2,957,325.96	3,751,096.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	91,717.00	5,528.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	44,612,899.43	8,039,722.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,612,899.43	8,039,722.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,446,556.34	ADJUSTMENTS	0.00
COVERED CHARGES	605,344.61	CONTRACTUAL ALLOW	511,855.48
NON-COVERD CHARGES	841,211.73	TOTAL MEDICAID LIAB	93,489.13
		LESS: COB	93,489.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 134

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,831.93	1,248.00
MED/SURG SUPPLY	2,250.00	502.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,187.00	0.00
CT SCAN	7,170.00	98,667.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,744.00	0.00
IV THERAPY	57,395.00	4,166.00
OPERATING ROOM	13,076.00	149,655.00
LABOR/DELIVERY ROOM	5,961.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	38,192.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	81,915.00	0.00
RECOVERY ROOM	19,089.00	2,583.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	8,993.00	29,426.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,331.00	1,032.00
PSYCHIATRIC SERVICES	561.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	38,171.00	51,499.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,788.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,309.00	330.00
AUDIOLOGY	501.00	885.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,609.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,330.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	468.00	0.00
OTHER THERAPEUTIC SVC	0.00	882.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	120,048.16	15,593.00
MRI SERVICES	19,767.00	17,352.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	180.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	89,273.52	447,488.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	10,172.00	15,935.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	605,344.61	841,211.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	605,344.61	841,211.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	923,581.83	ADJUSTMENTS	1,611.12
COVERED CHARGES	835,720.89	CONTRACTUAL ALLOW	821,422.20
NON-COVERD CHARGES	87,860.94	TOTAL MEDICAID LIAB	14,298.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	14,298.69

TOTAL NUMBER OF CLAIMS 213

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,174.15	0.00
MED/SURG SUPPLY	4,577.00	6,300.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,293.00	0.00
CT SCAN	99,728.00	64,846.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,488.00	0.00
IV THERAPY	74,977.00	516.00
OPERATING ROOM	11,282.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,020.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	397,063.00	0.00
RECOVERY ROOM	3,451.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	561.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,678.00	8,980.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,182.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	162,158.00	5,613.00
MRI SERVICES	16,119.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,969.74	1,605.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	835,720.89	87,860.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	835,720.89	87,860.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,710.68	ADJUSTMENTS	0.00
COVERED CHARGES	39,121.18	CONTRACTUAL ALLOW	38,718.40
NON-COVERD CHARGES	7,589.50	TOTAL MEDICAID LIAB	402.78
		LESS: COB	402.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,649.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	729.00	0.00
CT SCAN	11,872.00	3,447.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,017.00	1,175.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,517.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,512.00	2,470.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,512.00	282.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	313.18	215.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	39,121.18	7,589.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,121.18	7,589.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,940,001.82	ADJUSTMENTS	1,194,868.74
COVERED CHARGES	20,645,369.35	CONTRACTUAL ALLOW	16,143,369.93
NON-COVERD CHARGES	1,294,632.47	TOTAL MEDICAID LIAB	4,501,999.42
		LESS: COB	4,493.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,497,506.04

TOTAL NUMBER OF CLAIMS 846

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125,516.10	6,331.97
MED/SURG SUPPLY	700,001.00	43,725.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,764.00	114,532.00
CT SCAN	139,900.00	98,696.00
PHYSICAL THERAPY	0.00	6,007.00
EKG/ECG	16,995.00	1,872.00
IV THERAPY	1,626,135.00	19,245.00
OPERATING ROOM	2,523,912.00	382,315.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,406.00	2,676.00
ANESTHESIA	448,569.00	5,785.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	60,759.00	0.00
RECOVERY ROOM	282,335.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,321,071.00	6,675.00
OCCUPATIONAL THERAPY	0.00	7,315.00
SPEECH PATHOLOGY	0.00	3,530.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	145,521.00	3,093.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	59,608.00	0.00
OTHER IMAGING SERVICE	38,492.00	3,705.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,740.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	64,446.00	22,295.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,447.00	7,674.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	420,312.00	190.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,205.00	344.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,491,621.00	9,711.00
MRI SERVICES	52,804.00	7,414.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,181,370.25	382,413.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,793,440.00	159,088.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,645,369.35	1,294,632.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,645,369.35	1,294,632.47

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	298,407.00	ADJUSTMENTS	0.00
COVERED CHARGES	216,059.50	CONTRACTUAL ALLOW	194,900.50
NON-COVERD CHARGES	82,347.50	TOTAL MEDICAID LIAB	21,159.00
		LESS: COB	21,159.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,264.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,799.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	573.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,057.00	141.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,872.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,535.00	20,923.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,739.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93,772.50	11,796.50
RADIOLOGY THERAPEUTIC	1,342.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	516.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,126.00	41,395.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	7,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,812.00	0.00			

TOTAL ANCILLARY	216,059.50	82,347.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	216,059.50	82,347.50

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	575,825.64	ADJUSTMENTS	0.00
COVERED CHARGES	570,257.64	CONTRACTUAL ALLOW	463,203.40
NON-COVERD CHARGES	5,568.00	TOTAL MEDICAID LIAB	107,054.24
		LESS: COB	5,233.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	101,821.21

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	140	0	222,900.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	140	0	222,900.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	140	0	222,900.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,631.60	0.00
MED/SURG SUPPLY	3,344.51	0.00
LABORATORY-GENERAL	33,995.00	0.00
RADIOLOGY-DIAGNOSTIC	2,816.00	0.00
CT SCAN	17,394.00	0.00
PHYSICAL THERAPY	79,375.00	0.00
EKG/ECG	209.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,817.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	7,227.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,149.00	0.00
RECOVERY ROOM	1,762.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	87,522.00	0.00
SPEECH PATHOLOGY	15,555.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,376.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,629.00	5,568.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,899.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	643.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,914.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,031.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,068.53	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	347,357.64	5,568.00
TOTAL ACCOMODATIONS	222,900.00	0.00
TOTAL CHARGES	570,257.64	5,568.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/22	THROUGH	07/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/22	THROUGH	07/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,852,824.14	ADJUSTMENTS	14,829.72
COVERED CHARGES	1,829,844.00	CONTRACTUAL ALLOW	1,184,674.61
NON-COVERD CHARGES	22,980.14	TOTAL MEDICAID LIAB	645,169.39
		LESS: COB	10,150.97
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	635,018.42

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	266	0	245,518.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.14
TOTAL ROUTINE	266	0	245,518.00	0.14
SPECIAL CARE SERVICES				
CCU	143	0	153,010.00	0.00
ICU	49	0	55,370.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	192	0	208,380.00	0.00
TOTAL ACCOMODATIONS	458	0	453,898.00	0.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	316,537.45	0.00
MED/SURG SUPPLY	1,472.66	0.00
LABORATORY-GENERAL	363,214.51	0.00
RADIOLOGY-DIAGNOSTIC	25,254.35	0.00
CT SCAN	156,083.33	0.00
PHYSICAL THERAPY	4,695.35	0.00
EKG/ECG	9,133.50	0.00
IV THERAPY	23,762.85	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	125,835.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	141,298.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,599.05	0.00
SPEECH PATHOLOGY	481.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	49.60	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,898.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	56,710.85	22,980.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,369.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	24,757.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,095.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	124.75	0.00
OTHER THERAPEUTIC SVC	56,560.35	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,147.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	37,446.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	418.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,375,946.00	22,980.00
TOTAL ACCOMODATIONS	453,898.00	0.14
TOTAL CHARGES	1,829,844.00	22,980.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,972.50	ADJUSTMENTS	0.00
COVERED CHARGES	24,972.50	CONTRACTUAL ALLOW	14,699.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,272.55
		LESS: COB	10,272.55
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4	0	3,692.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	3,692.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	2,140.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	2,140.00	0.00
TOTAL ACCOMODATIONS	6	0	5,832.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,273.85	0.00
MED/SURG SUPPLY	34.65	0.00
LABORATORY-GENERAL	3,285.75	0.00
RADIOLOGY-DIAGNOSTIC	391.90	0.00
CT SCAN	2,087.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	263.70	0.00
IV THERAPY	213.90	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	963.90	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,087.70	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,759.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	736.50	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,041.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,140.50	0.00
TOTAL ACCOMODATIONS	5,832.00	0.00
TOTAL CHARGES	24,972.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,940,671.50	ADJUSTMENTS	186,510.71
COVERED CHARGES	2,779,228.23	CONTRACTUAL ALLOW	2,075,484.73
NON-COVERD CHARGES	161,443.27	TOTAL MEDICAID LIAB	703,743.50
		LESS: COB	1,893.92
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	701,849.58
		ALL OTHER	604,214.42
		FEE SCHEDULE-LAB	84,363.58
		INJECTABLE DRUGS	13,271.58

TOTAL NUMBER OF CLAIMS 1,446

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,441.30	0.00
MED/SURG SUPPLY	8,923.09	79.70
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,930.40	2,107.25
CT SCAN	678,450.70	44,229.90
PHYSICAL THERAPY	11,325.55	231.60
EKG/ECG	26,897.40	1,154.65
IV THERAPY	41,413.70	5,843.45
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29,200.65	20,498.75
ANESTHESIA	2,152.75	0.00
GI SERVICES	8,671.80	8,694.40
EMERGENCY ROOM	690,709.40	1,894.25
RECOVERY ROOM	3,949.55	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,121.20	3,016.50
SPEECH PATHOLOGY	1,038.05	2,806.80
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,537.20	198.40
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	60,061.35	5,213.95
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	15,200.55	919.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,632.00	8,639.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,934.70	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	28,004.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	22,607.90	790.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	137,319.35	24,836.10
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	708,898.29	14,928.47
MRI SERVICES	16,855.10	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	112,951.85	13,365.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	1,994.95

TOTAL ANCILLARY	2,779,228.23	161,443.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,779,228.23	161,443.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023339038041	12/01/23 - 12/01/23	12/11/23	0.00	1,994.95	0.00	0.00	0.00
TOTAL				0.00	1,994.95	0.00	0.00	0.00

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,829.35	ADJUSTMENTS	0.00
COVERED CHARGES	33,611.25	CONTRACTUAL ALLOW	24,767.33
NON-COVERD CHARGES	4,218.10	TOTAL MEDICAID LIAB	8,843.92
		LESS: COB	8,843.92
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	821.65	0.00
MED/SURG SUPPLY	119.55	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,348.05	0.00
CT SCAN	8,893.10	3,972.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	263.70	0.00
IV THERAPY	411.05	197.15
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	59.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,070.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	396.65	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	2,061.15	48.75
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,242.80	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	923.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,611.25	4,218.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,611.25	4,218.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	201,158.55	ADJUSTMENTS	365.00
COVERED CHARGES	191,879.15	CONTRACTUAL ALLOW	179,769.15
NON-COVERD CHARGES	9,279.40	TOTAL MEDICAID LIAB	12,110.00
		LESS: COB	104.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,005.87

TOTAL NUMBER OF CLAIMS 173

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,078.55	0.00
MED/SURG SUPPLY	79.70	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,081.30	147.30
CT SCAN	9,925.10	6,817.45
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,977.75	0.00
IV THERAPY	2,021.75	197.15
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	109,146.85	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	24.80	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,511.80	1,066.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	440.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	9,842.85	538.35
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,423.70	477.05
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,324.20	35.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	191,879.15	9,279.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	191,879.15	9,279.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,342.15	ADJUSTMENTS	0.00
COVERED CHARGES	8,293.40	CONTRACTUAL ALLOW	7,803.40
NON-COVERD CHARGES	48.75	TOTAL MEDICAID LIAB	490.00
		LESS: COB	490.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140.20	0.00	OTHER THERAPEUTIC SVC	440.85	48.75
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,859.10	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	197.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,651.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	489.30	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,293.40	48.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,293.40	48.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,146.90	ADJUSTMENTS	0.00
COVERED CHARGES	19,366.55	CONTRACTUAL ALLOW	14,260.40
NON-COVERD CHARGES	1,780.35	TOTAL MEDICAID LIAB	5,106.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,106.15

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.00	0.00
MED/SURG SUPPLY	39.85	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	343.25	0.00
CT SCAN	14,890.75	1,256.40
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	131.85	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,665.45	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	481.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,294.40	42.95
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	19,366.55	1,780.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,366.55	1,780.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,094,733.92	ADJUSTMENTS	10,806.53
COVERED CHARGES	1,093,621.92	CONTRACTUAL ALLOW	760,197.45
NON-COVERD CHARGES	1,112.00	TOTAL MEDICAID LIAB	333,424.47
		LESS: COB	2,292.24
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	331,132.23

TOTAL NUMBER OF ADMISSIONS 50

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	152	0	244,416.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	152	0	244,416.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	26	0	62,970.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	26	0	62,970.00	0.00
TOTAL ACCOMODATIONS	178	0	307,386.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,781.86	0.00
MED/SURG SUPPLY	2,125.94	0.00
LABORATORY-GENERAL	83,061.56	0.00
RADIOLOGY-DIAGNOSTIC	15,465.56	0.00
CT SCAN	57,340.00	0.00
PHYSICAL THERAPY	25,919.00	0.00
EKG/ECG	19,966.00	0.00
IV THERAPY	1,146.00	0.00
OPERATING ROOM	29,093.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	120,722.37	0.00
ANESTHESIA	3,645.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	259,831.60	0.00
RECOVERY ROOM	1,846.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	13,172.30	0.00
SPEECH PATHOLOGY	3,197.92	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	456.83	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,020.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,858.00	1,112.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,232.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,020.47	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	25,081.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,436.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,415.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,245.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,157.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,000.00	0.00

TOTAL ANCILLARY	786,235.92	1,112.00
TOTAL ACCOMODATIONS	307,386.00	0.00
TOTAL CHARGES	1,093,621.92	1,112.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2223352005966	11/13/23 - 11/16/23	12/25/23	1,000.00	0.00	0.00	0.00	0.00
TOTAL				1,000.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,492,171.07	ADJUSTMENTS	116,798.83
COVERED CHARGES	3,366,536.07	CONTRACTUAL ALLOW	2,644,956.68
NON-COVERD CHARGES	125,635.00	TOTAL MEDICAID LIAB	721,579.39
		LESS: COB	6,083.90
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	715,495.49
		ALL OTHER	664,506.32
		FEE SCHEDULE-LAB	46,327.39
		INJECTABLE DRUGS	4,661.78

TOTAL NUMBER OF CLAIMS 1,239

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,635.87	557.64
MED/SURG SUPPLY	15,476.14	1,112.98
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,385.36	0.00
CT SCAN	247,660.00	14,405.00
PHYSICAL THERAPY	0.00	1,806.00
EKG/ECG	55,428.00	0.00
IV THERAPY	356,287.14	956.41
OPERATING ROOM	207,686.00	23,078.00
LABOR/DELIVERY ROOM	222.00	0.00
RESPIRATORY SERVICES	19,844.26	2,951.00
ANESTHESIA	25,695.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,642,416.40	2,100.00
RECOVERY ROOM	29,507.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	287.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	368.82	116.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	33,977.60	2,828.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,957.41	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/OBSERV. RM	293,114.00	13,362.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	27,367.16	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	222,422.24	13,959.76
MRI SERVICES	27,000.00	1,415.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,922.67	40,487.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	163.00	6,213.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,366,536.07	125,635.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,366,536.07	125,635.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	81,949.33	ADJUSTMENTS	0.00
COVERED CHARGES	63,442.91	CONTRACTUAL ALLOW	49,724.62
NON-COVERD CHARGES	18,506.42	TOTAL MEDICAID LIAB	13,718.29
		LESS: COB	13,718.29
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.74	11.05
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,871.00	0.00
CT SCAN	850.00	2,545.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	596.00	0.00
IV THERAPY	2,434.00	0.00
OPERATING ROOM	17,750.00	7,650.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,195.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,250.00	0.00
RECOVERY ROOM	4,529.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,653.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,181.00	864.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	407.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,028.00	472.00
MRI SERVICES	0.00	1,415.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	335.17	156.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	5,393.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	63,442.91	18,506.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	63,442.91	18,506.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,477.12	ADJUSTMENTS	134.26
COVERED CHARGES	161,921.87	CONTRACTUAL ALLOW	157,558.42
NON-COVERD CHARGES	555.25	TOTAL MEDICAID LIAB	4,363.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,363.45

TOTAL NUMBER OF CLAIMS 65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.48	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,333.00	0.00
CT SCAN	4,095.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,788.00	0.00
IV THERAPY	4,779.45	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	139,800.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,718.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,080.84	304.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	270.10	251.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	161,921.87	555.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	161,921.87	555.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,404.59	ADJUSTMENTS	0.00
COVERED CHARGES	36,992.64	CONTRACTUAL ALLOW	36,119.95
NON-COVERD CHARGES	411.95	TOTAL MEDICAID LIAB	872.69
		LESS: COB	872.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.05	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	920.64	316.64
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	894.00	0.00
IV THERAPY	880.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,984.41	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,748.72	91.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,541.82	4.31
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	36,992.64	411.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,992.64	411.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	273,528.26	ADJUSTMENTS	0.00
COVERED CHARGES	243,868.02	CONTRACTUAL ALLOW	216,110.22
NON-COVERD CHARGES	29,660.24	TOTAL MEDICAID LIAB	27,757.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	27,757.80

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288.83	67.95
MED/SURG SUPPLY	21,599.63	1,845.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,172.56	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	5,284.00
EKG/ECG	298.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	133,800.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,635.00	4,743.00
ANESTHESIA	22,305.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,631.24	0.00
RECOVERY ROOM	5,654.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,176.86
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,224.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,336.24	144.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	664.06	3,593.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	37,259.46	11,806.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	243,868.02	29,660.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	243,868.02	29,660.24

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,650,802.08	ADJUSTMENTS	2,567,517.96
COVERED CHARGES	85,428,460.52	CONTRACTUAL ALLOW	68,002,687.65
NON-COVERD CHARGES	1,222,341.56	TOTAL MEDICAID LIAB	17,425,772.87
		LESS: COB	205,581.10
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	17,220,191.77

TOTAL NUMBER OF ADMISSIONS 1,665

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,449	0	9,725,057.00	0.00
ROUTINE NURSERY	1,041	0	1,658,881.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9,490	0	11,383,938.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,548	0	3,939,371.00	0.00
NICU	456	0	1,594,296.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,004	0	5,533,667.00	0.00
TOTAL ACCOMODATIONS	11,494	0	16,917,605.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,532,532.41	0.00
MED/SURG SUPPLY	791,058.50	0.00
LABORATORY-GENERAL	11,246,072.00	0.00
RADIOLOGY-DIAGNOSTIC	1,497,182.00	0.00
CT SCAN	5,475,218.00	52,227.00
PHYSICAL THERAPY	778,882.00	0.00
EKG/ECG	375,171.00	0.00
IV THERAPY	328,623.00	0.00
OPERATING ROOM	6,933,208.00	7,563.00
LABOR/DELIVERY ROOM	446,563.00	0.00
RESPIRATORY SERVICES	5,127,585.00	0.00
ANESTHESIA	1,619,491.00	0.00
GI SERVICES	253,555.00	4,966.00
EMERGENCY ROOM	3,859,044.00	0.00
RECOVERY ROOM	857,878.00	0.00
LABORATORY PATHOLOGIC	209,226.00	0.00
RADIOLOGY THERAPEUTIC	331,430.00	0.00
OCCUPATIONAL THERAPY	430,661.00	0.00
SPEECH PATHOLOGY	253,729.00	0.00
RENAL DIALYSIS	48,796.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,371.00	42,152.00
PSYCHIATRIC SERVICES	78,840.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	601,083.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	566,815.00	1,002,240.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	179,675.00	29,253.56
AUDIOLOGY	112,487.00	0.00
CARDIOLOGY	3,063,134.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	86,807.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,272,447.33	8,385.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	574,754.00	0.00
RECREATIONAL THERAPY	796.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	74,472.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,177,526.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	775,230.43	958.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,614,291.85	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	3,693.00	125.00

TOTAL ANCILLARY	68,510,855.52	1,222,341.56
TOTAL ACCOMODATIONS	16,917,605.00	0.00
TOTAL CHARGES	85,428,460.52	1,222,341.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022242064893	08/20/22 - 08/23/22	09/05/22	3,693.00	0.00	0.00	0.00	0.00
780	2323325000087	05/05/23 - 05/16/23	11/27/23	0.00	125.00	0.00	2,144.25	0.00
TOTAL				3,693.00	125.00	0.00	2,144.25	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	549,191.20	ADJUSTMENTS	0.00
COVERED CHARGES	544,882.20	CONTRACTUAL ALLOW	411,311.58
NON-COVERD CHARGES	4,309.00	TOTAL MEDICAID LIAB	133,570.62
		LESS: COB	133,570.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	31	0	32,085.00	0.00
ROUTINE NURSERY	42	0	75,088.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	73	0	107,173.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	41	0	133,328.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	41	0	133,328.00	0.00
TOTAL ACCOMODATIONS	114	0	240,501.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,221.27	0.00
MED/SURG SUPPLY	7,881.16	0.00
LABORATORY-GENERAL	53,169.00	0.00
RADIOLOGY-DIAGNOSTIC	3,785.00	0.00
CT SCAN	11,521.00	0.00
PHYSICAL THERAPY	5,096.00	0.00
EKG/ECG	418.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,444.00	0.00
LABOR/DELIVERY ROOM	9,456.00	0.00
RESPIRATORY SERVICES	27,670.00	0.00
ANESTHESIA	10,913.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,365.00	0.00
RECOVERY ROOM	17,184.00	0.00
LABORATORY PATHOLOGIC	1,556.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,895.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	177.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,498.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,268.00	3,712.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,713.00	0.00
CARDIOLOGY	7,873.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,719.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,601.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	597.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,311.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,428.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	3,218.25	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	304,381.20	4,309.00
TOTAL ACCOMODATIONS	240,501.00	0.00
TOTAL CHARGES	544,882.20	4,309.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,396,092.11	ADJUSTMENTS	974,992.90
COVERED CHARGES	40,999,455.91	CONTRACTUAL ALLOW	33,266,091.33
NON-COVERD CHARGES	6,396,636.20	TOTAL MEDICAID LIAB	7,733,364.58
		LESS: COB	5,739.01
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,727,625.57
		ALL OTHER	5,286,951.56
		FEE SCHEDULE-LAB	591,340.06
		INJECTABLE DRUGS	1,849,333.95

TOTAL NUMBER OF CLAIMS 12,458

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,208,575.96	55,817.84
MED/SURG SUPPLY	123,956.59	0.00
LABORATORY-GENERAL	0.00	3,132.00
RADIOLOGY-DIAGNOSTIC	943,038.00	35,378.00
CT SCAN	3,367,871.00	360,722.00
PHYSICAL THERAPY	117,559.00	29,376.00
EKG/ECG	288,512.00	1,881.00
IV THERAPY	2,746,671.00	107,120.00
OPERATING ROOM	3,251,421.59	718,123.41
LABOR/DELIVERY ROOM	8,790.00	0.00
RESPIRATORY SERVICES	120,095.00	111,275.00
ANESTHESIA	1,751,124.00	0.00
GI SERVICES	1,066,062.36	236,526.66
EMERGENCY ROOM	3,798,666.17	58,803.00
RECOVERY ROOM	1,215,721.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,908,544.00	116,814.00
OCCUPATIONAL THERAPY	54,375.00	26,015.00
SPEECH PATHOLOGY	21,318.00	8,884.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	790,740.00	16,102.00
PSYCHIATRIC SERVICES	64,980.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	999,438.50	28,339.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	413,809.00	20,106.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	366,916.00	61,140.00
AUDIOLOGY	2,284.00	0.00
CARDIOLOGY	639,031.00	380,939.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	541,965.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	410,555.51	35,328.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	331,339.00	2,385.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,514.00	0.00
OTHER THERAPEUTIC SVC	0.00	7,560.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,786,577.50	441,775.50
MRI SERVICES	641,463.00	72,611.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	5,134.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,671,289.76	3,397,732.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	334,633.97	57,616.75
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	9,619.00	0.00

TOTAL ANCILLARY	40,999,455.91	6,396,636.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,999,455.91	6,396,636.20

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022257057020	09/09/22 - 09/09/22	09/19/22	125.00	0.00	0.00	0.00	20.52
780	2022259062247	09/09/22 - 09/09/22	09/19/22	125.00	0.00	0.00	0.00	20.52
780	2022259062250	09/09/22 - 09/09/22	09/19/22	125.00	0.00	0.00	0.00	20.52
780	2022259062251	09/08/22 - 09/08/22	09/19/22	125.00	0.00	0.00	0.00	20.52
780	2022263065300	09/08/22 - 09/08/22	09/26/22	125.00	0.00	0.00	0.00	20.52
780	2022264020514	09/09/22 - 09/09/22	09/26/22	125.00	0.00	0.00	0.00	20.52
780	2022264064835	09/09/22 - 09/09/22	09/26/22	125.00	0.00	0.00	0.00	20.52
780	2022312053174	11/03/22 - 11/03/22	11/14/22	125.00	0.00	0.00	0.00	20.52
780	2022314083522	11/04/22 - 11/04/22	11/14/22	125.00	0.00	0.00	0.00	20.52
780	2022314083523	11/04/22 - 11/04/22	11/14/22	125.00	0.00	0.00	0.00	20.52
780	2022314083529	11/04/22 - 11/04/22	11/14/22	125.00	0.00	0.00	0.00	20.52
780	2022314083530	11/04/22 - 11/04/22	11/14/22	125.00	0.00	0.00	0.00	20.52
780	2022322071636	11/04/22 - 11/04/22	11/21/22	125.00	0.00	0.00	0.00	20.52
780	2022322071637	11/03/22 - 11/03/22	11/21/22	125.00	0.00	0.00	0.00	20.52
780	2022322071641	11/04/22 - 11/04/22	11/21/22	125.00	0.00	0.00	0.00	20.52
780	2023006090325	11/03/22 - 11/03/22	01/09/23	125.00	0.00	0.00	0.00	20.52
780	2023012056445	01/05/23 - 01/05/23	01/16/23	125.00	0.00	0.00	0.00	20.52
780	2023016015795	01/06/23 - 01/06/23	01/23/23	125.00	0.00	0.00	0.00	20.52
780	2023016015796	01/06/23 - 01/06/23	01/23/23	125.00	0.00	0.00	0.00	20.52
780	2023016019851	01/05/23 - 01/05/23	01/23/23	125.00	0.00	0.00	0.00	20.52
780	2023031067966	01/06/23 - 01/06/23	02/06/23	125.00	0.00	0.00	0.00	20.52
780	2023033094298	01/06/23 - 01/06/23	02/06/23	125.00	0.00	0.00	0.00	20.52
780	2023068093118	03/03/23 - 03/03/23	03/13/23	125.00	0.00	0.00	0.00	20.52
780	2023069082420	03/03/23 - 03/03/23	03/13/23	125.00	0.00	0.00	0.00	20.52
780	2023070028710	03/03/23 - 03/03/23	03/20/23	125.00	0.00	0.00	0.00	20.52
615	2023112025828	02/14/23 - 02/14/23	05/01/23	4,494.00	0.00	0.00	0.00	856.25
780	2023129059813	05/04/23 - 05/04/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023131078958	05/04/23 - 05/04/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023132061170	05/04/23 - 05/04/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023132061171	05/05/23 - 05/05/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023132061172	05/04/23 - 05/04/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023132061173	05/04/23 - 05/04/23	05/15/23	125.00	0.00	0.00	0.00	20.52
780	2023133034118	05/05/23 - 05/05/23	05/22/23	125.00	0.00	0.00	0.00	20.52
780	2023135033177	05/05/23 - 05/05/23	05/22/23	125.00	0.00	0.00	0.00	20.52
780	2023139106304	05/04/23 - 05/04/23	05/29/23	125.00	0.00	0.00	0.00	20.52
780	2023150052006	05/04/23 - 05/04/23	06/05/23	125.00	0.00	0.00	0.00	20.52
780	2023177004634	05/05/23 - 05/05/23	07/03/23	125.00	0.00	0.00	0.00	20.52
780	2023188106605	06/22/23 - 06/22/23	07/10/23	125.00	0.00	0.00	0.00	20.52
780	2023195072123	07/07/23 - 07/07/23	07/24/23	125.00	0.00	0.00	0.00	20.52
780	2023202056831	07/06/23 - 07/06/23	07/24/23	125.00	0.00	0.00	0.00	20.52
780	2023202056833	07/06/23 - 07/06/23	07/24/23	125.00	0.00	0.00	0.00	20.52
780	2023216086846	07/24/23 - 07/24/23	08/07/23	125.00	0.00	0.00	0.00	20.52

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

TOTAL	9,619.00	0.00	0.00	0.00	1,697.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	423,825.92	ADJUSTMENTS	0.00
COVERED CHARGES	277,197.59	CONTRACTUAL ALLOW	231,523.91
NON-COVERD CHARGES	146,628.33	TOTAL MEDICAID LIAB	45,673.68
		LESS: COB	45,673.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,161.72	5,091.71
MED/SURG SUPPLY	1,299.77	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,347.00	452.00
CT SCAN	6,338.00	38,414.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,135.00	0.00
IV THERAPY	10,629.00	0.00
OPERATING ROOM	26,987.00	52,985.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	225.00	352.00
ANESTHESIA	19,774.00	0.00
GI SERVICES	2,697.50	16,035.50
EMERGENCY ROOM	42,928.00	1,262.00
RECOVERY ROOM	18,027.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	25,221.00	0.00
OCCUPATIONAL THERAPY	3,356.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,950.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,644.00	19,241.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,884.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,394.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,789.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,168.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	808.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,691.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,637.00	2,694.00
MRI SERVICES	0.00	1,640.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,520.60	4,899.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,772.87
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	375.00	0.00

TOTAL ANCILLARY	277,197.59	146,628.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	277,197.59	146,628.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
780	2022334066531	11/04/22 - 11/04/22	12/05/22	125.00	0.00	0.00	48.65	0.00
780	2023013081222	09/08/22 - 09/08/22	01/16/23	125.00	0.00	0.00	60.96	0.00
780	2023151050758	05/05/23 - 05/05/23	06/05/23	125.00	0.00	0.00	45.73	0.00
TOTAL				375.00	0.00	0.00	155.34	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	678,144.00	ADJUSTMENTS	469.91
COVERED CHARGES	650,933.00	CONTRACTUAL ALLOW	634,083.37
NON-COVERD CHARGES	27,211.00	TOTAL MEDICAID LIAB	16,849.63
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	16,849.63

TOTAL NUMBER OF CLAIMS 251

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,422.00	446.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,269.00	461.00
CT SCAN	118,696.00	2,272.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,987.00	0.00
IV THERAPY	51,071.00	817.00
OPERATING ROOM	3,054.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	450.00	352.00
ANESTHESIA	596.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	265,376.00	1,023.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,896.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	326.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	8,390.00	960.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,399.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	435.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	957.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,267.00	6,634.00
MRI SERVICES	0.00	9,292.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28,342.00	4,954.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	650,933.00	27,211.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	650,933.00	27,211.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,977.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,730.00	CONTRACTUAL ALLOW	8,461.48
NON-COVERD CHARGES	247.00	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103.00	32.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	694.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	418.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,794.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,276.00	32.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	445.00	183.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,730.00	247.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,730.00	247.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,061,913.80	ADJUSTMENTS	459,842.25
COVERED CHARGES	14,857,480.92	CONTRACTUAL ALLOW	13,158,303.82
NON-COVERD CHARGES	2,204,432.88	TOTAL MEDICAID LIAB	1,699,177.10
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,699,177.10

TOTAL NUMBER OF CLAIMS 303

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	414,007.08	2,621.00
MED/SURG SUPPLY	177,997.27	0.00
LABORATORY-GENERAL	0.00	196.00
RADIOLOGY-DIAGNOSTIC	24,507.00	14,319.00
CT SCAN	29,464.00	15,583.00
PHYSICAL THERAPY	1,542.00	19,675.00
EKG/ECG	12,749.00	1,066.00
IV THERAPY	215,742.00	12,885.00
OPERATING ROOM	2,709,568.75	314,672.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,250.00	225.00
ANESTHESIA	666,549.00	0.00
GI SERVICES	7,814.00	0.00
EMERGENCY ROOM	16,485.00	0.00
RECOVERY ROOM	339,647.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,247,625.00	23,542.00
OCCUPATIONAL THERAPY	0.00	633.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,673.00	1,907.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	21,200.00	0.00
OTHER IMAGING SERVICE	5,837.00	11,199.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,380.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,979.00	1,742.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	126,803.00	1,285,458.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	23,464.48	3,438.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	540.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	141,900.00	40,966.50
MRI SERVICES	3,280.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,542,078.62	453,765.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	2,094,938.72	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,857,480.92	2,204,432.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,857,480.92	2,204,432.88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,778,040.75	ADJUSTMENTS	276,077.31
COVERED CHARGES	10,728,099.75	CONTRACTUAL ALLOW	8,956,637.00
NON-COVERD CHARGES	49,941.00	TOTAL MEDICAID LIAB	1,771,462.75
		LESS: COB	14,467.29
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	52,323.00
		REIMBURSEMENT	1,809,318.46

TOTAL NUMBER OF ADMISSIONS 256

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	689	0	1,219,724.00	0.00
ROUTINE NURSERY	105	0	130,093.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	8.00
TOTAL ROUTINE	794	0	1,349,817.00	8.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	156	0	831,012.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	156	0	831,012.00	0.00
TOTAL ACCOMODATIONS	950	0	2,180,829.00	8.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,177,309.03	0.00
MED/SURG SUPPLY	161,304.59	0.00
LABORATORY-GENERAL	1,922,970.00	0.00
RADIOLOGY-DIAGNOSTIC	99,997.00	0.00
CT SCAN	900,257.29	2,629.00
PHYSICAL THERAPY	63,289.00	0.00
EKG/ECG	77,420.00	0.00
IV THERAPY	288,617.00	0.00
OPERATING ROOM	559,246.00	0.00
LABOR/DELIVERY ROOM	386,917.00	279.00
RESPIRATORY SERVICES	795,812.00	0.00
ANESTHESIA	66,952.00	0.00
GI SERVICES	103,931.00	0.00
EMERGENCY ROOM	568,547.00	0.00
RECOVERY ROOM	286,385.00	0.00
LABORATORY PATHOLOGIC	16,498.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	47,320.00	0.00
RENAL DIALYSIS	151,362.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,208.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	52,085.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	74,071.00	46,337.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,701.00	688.00
AUDIOLOGY	28,392.00	0.00
CARDIOLOGY	200,469.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	149,181.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	87,908.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	223,173.02	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	41,948.32	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	8,547,270.75	49,933.00
TOTAL ACCOMODATIONS	2,180,829.00	8.00
TOTAL CHARGES	10,728,099.75	49,941.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	114,365.43	ADJUSTMENTS	0.00
COVERED CHARGES	114,365.43	CONTRACTUAL ALLOW	97,968.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	16,396.93
		LESS: COB	16,396.93
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	5	0	9,120.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	9,120.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	21,308.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	21,308.00	0.00
TOTAL ACCOMODATIONS	9	0	30,428.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,450.43	0.00	OTHER LAB	1,835.00	0.00
MED/SURG SUPPLY	353.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,448.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,424.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,798.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,212.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,286.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,776.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,330.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,495.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,530.00	0.00			

TOTAL ANCILLARY	83,937.43	0.00
TOTAL ACCOMODATIONS	30,428.00	0.00
TOTAL CHARGES	114,365.43	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,196,267.07	ADJUSTMENTS	134,210.04
COVERED CHARGES	9,095,485.93	CONTRACTUAL ALLOW	7,929,458.66
NON-COVERD CHARGES	1,100,781.14	TOTAL MEDICAID LIAB	1,166,027.27
		LESS: COB	5,362.53
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,160,664.74
		ALL OTHER	1,059,173.10
		FEE SCHEDULE-LAB	89,030.40
		INJECTABLE DRUGS	12,461.24

TOTAL NUMBER OF CLAIMS 1,883

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,452.08	1,792.14
MED/SURG SUPPLY	135,365.13	9,142.68
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	336,003.00	6,662.00
CT SCAN	1,757,858.00	232,256.04
PHYSICAL THERAPY	0.00	5,885.00
EKG/ECG	138,250.00	8,295.00
IV THERAPY	701,956.00	91,711.00
OPERATING ROOM	450,077.67	53,549.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	69,322.00	5,369.00
ANESTHESIA	46,109.00	0.00
GI SERVICES	146,450.00	69,003.00
EMERGENCY ROOM	2,275,522.00	7,428.00
RECOVERY ROOM	133,757.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,604.00	7,324.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	310.00	1,550.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	187,676.00	26,342.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,932.00	5,884.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,510.00	130,081.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	114,576.00	54,667.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	83,241.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	346,265.36	6,704.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	146,882.00	4,869.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,649,459.00	88,587.00
MRI SERVICES	114,105.00	79,434.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	122,588.39	192,906.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	8,215.30	11,339.60
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	9,095,485.93	1,100,781.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,095,485.93	1,100,781.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,675.89	ADJUSTMENTS	0.00
COVERED CHARGES	164,131.07	CONTRACTUAL ALLOW	142,430.81
NON-COVERD CHARGES	20,544.82	TOTAL MEDICAID LIAB	21,700.26
		LESS: COB	21,700.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,843.05	249.60
MED/SURG SUPPLY	6,749.96	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,984.00	0.00
CT SCAN	0.00	7,671.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.00	0.00
IV THERAPY	6,110.00	0.00
OPERATING ROOM	54,192.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	8,390.00	0.00
GI SERVICES	4,525.00	3,941.00
EMERGENCY ROOM	9,770.00	0.00
RECOVERY ROOM	21,176.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,682.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,466.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,423.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,505.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,100.00	1,121.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	416.70	7,562.22
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	245.36	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	164,131.07	20,544.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	164,131.07	20,544.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,109,048.16	ADJUSTMENTS	391.62
COVERED CHARGES	1,067,278.41	CONTRACTUAL ALLOW	1,049,813.02
NON-COVERD CHARGES	41,769.75	TOTAL MEDICAID LIAB	17,465.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	17,465.39

TOTAL NUMBER OF CLAIMS 226

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,308.04	83.20
MED/SURG SUPPLY	0.00	286.98
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,852.00	0.00
CT SCAN	300,958.00	10,407.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	17,143.00	1,106.00
IV THERAPY	95,954.00	18,802.00
OPERATING ROOM	5,565.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	643.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	428,876.03	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,138.00	595.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,160.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,737.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	121,552.00	6,110.00
MRI SERVICES	15,913.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,479.34	4,379.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,067,278.41	41,769.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,067,278.41	41,769.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,224.82	ADJUSTMENTS	0.00
COVERED CHARGES	5,224.82	CONTRACTUAL ALLOW	5,068.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	248.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,018.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,958.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,224.82	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,224.82	0.00

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	383,045.69	ADJUSTMENTS	0.00
COVERED CHARGES	291,368.89	CONTRACTUAL ALLOW	259,630.39
NON-COVERD CHARGES	91,676.80	TOTAL MEDICAID LIAB	31,738.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	31,738.50

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,149.24	83.20
MED/SURG SUPPLY	16,059.09	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,810.00	0.00
CT SCAN	13,049.00	0.00
PHYSICAL THERAPY	0.00	1,658.00
EKG/ECG	2,212.00	0.00
IV THERAPY	21,370.00	3,899.00
OPERATING ROOM	101,517.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,070.00	1,661.00
ANESTHESIA	15,552.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,179.00	1,756.00
RECOVERY ROOM	60,832.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,429.00	1,204.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,140.56	5,528.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	75,887.16
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	291,368.89	91,676.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	291,368.89	91,676.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC
1266 HIGHWAY 515 S
JASPER,GA 30143-4872

PROVIDER NUMBER
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	126,454,379.18	ADJUSTMENTS	7,395,016.91
COVERED CHARGES	125,776,309.98	CONTRACTUAL ALLOW	107,230,464.13
NON-COVERD CHARGES	678,069.20	TOTAL MEDICAID LIAB	18,545,845.85
		LESS: COB	194,721.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	441.00
		REIMBURSEMENT	18,351,565.04

TOTAL NUMBER OF ADMISSIONS 1,096

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,961	0	15,587,455.00	0.00
ROUTINE NURSERY	263	0	1,110,564.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	26.00
TOTAL ROUTINE	7,224	0	16,698,019.00	26.00
SPECIAL CARE SERVICES				
CCU	5	0	32,325.00	0.00
ICU	1,378	0	9,459,935.00	0.00
NICU	5	0	37,890.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,388	0	9,530,150.00	0.00
TOTAL ACCOMODATIONS	8,612	0	26,228,169.00	26.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,473,307.70	0.00
MED/SURG SUPPLY	6,769,629.98	151,858.20
LABORATORY-GENERAL	19,854,533.00	0.00
RADIOLOGY-DIAGNOSTIC	1,417,897.00	0.00
CT SCAN	5,206,509.32	39,642.00
PHYSICAL THERAPY	989,742.00	0.00
EKG/ECG	851,067.00	0.00
IV THERAPY	1,061,983.00	0.00
OPERATING ROOM	11,830,378.00	0.00
LABOR/DELIVERY ROOM	46,035.00	279.00
RESPIRATORY SERVICES	8,359,258.00	0.00
ANESTHESIA	1,500,440.00	0.00
GI SERVICES	1,262,981.00	0.00
EMERGENCY ROOM	2,819,861.50	0.00
RECOVERY ROOM	885,271.00	0.00
LABORATORY PATHOLOGIC	501,856.00	0.00
RADIOLOGY THERAPEUTIC	447,160.00	0.00
OCCUPATIONAL THERAPY	456,911.00	0.00
SPEECH PATHOLOGY	332,773.00	0.00
RENAL DIALYSIS	3,507,702.00	116,747.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,922.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	402,152.00	8,481.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,245,464.00	320,586.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	150,231.02	40,450.00
AUDIOLOGY	1,014.00	0.00
CARDIOLOGY	5,603,605.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	612,356.00	0.00
ORGAN ACQUISITION	1,500,172.00	0.00
TREATMENT/OBSERV. RM	520,007.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	756,244.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	14,784.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,184,191.33	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	5,868,864.11	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	108,839.02	0.00

TOTAL ANCILLARY	99,548,140.98	678,043.20
TOTAL ACCOMODATIONS	26,228,169.00	26.00
TOTAL CHARGES	125,776,309.98	678,069.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	5222347000657	08/09/22 - 08/10/22	01/09/23	6,222.00	0.00	0.00	0.00	0.00
614	5222347000796	09/03/22 - 09/20/22	01/09/23	6,222.00	0.00	0.00	0.00	0.00
614	5222347000838	10/09/22 - 10/13/22	01/09/23	5,269.00	0.00	0.00	0.00	0.00
614	2022363035431	12/04/22 - 12/20/22	01/02/23	5,269.00	0.00	0.00	0.00	0.00
614	2023016007054	12/29/22 - 01/11/23	01/23/23	6,222.00	0.00	0.00	0.00	0.00
614	2023044011735	02/05/23 - 02/09/23	02/20/23	5,269.00	0.00	0.00	0.00	0.00
614	5223050000003	08/05/22 - 09/10/22	02/27/23	5,269.00	0.00	0.00	0.00	0.00
614	2023053039265	02/04/23 - 02/16/23	02/27/23	6,222.00	0.00	0.00	0.00	0.00
614	2223061011789	01/13/23 - 01/20/23	03/06/23	5,269.00	0.00	0.00	0.00	0.00
614	5223061000334	10/26/22 - 11/11/22	03/06/23	6,222.00	0.00	0.00	0.00	0.00
614	5923075000489	01/01/23 - 01/10/23	03/20/23	5,269.00	0.00	0.00	0.00	0.00
614	5923107000178	02/06/23 - 02/19/23	04/24/23	5,269.00	0.00	0.00	0.00	0.00
614	2023132042253	04/27/23 - 05/08/23	05/15/23	5,269.00	0.00	0.00	0.00	0.00
614	2023140030250	05/13/23 - 05/17/23	05/29/23	5,269.00	0.00	0.00	0.00	0.00
614	2223171003636	04/17/23 - 04/20/23	06/26/23	6,222.00	0.00	0.00	0.00	0.00
614	2023252024532	02/24/23 - 03/08/23	09/18/23	5,269.00	0.00	0.00	0.00	0.00
615	2023252024532	02/24/23 - 03/08/23	09/18/23	8,139.00	0.00	0.00	0.00	0.00
615	2024184043405	03/30/23 - 04/08/23	07/08/24	4,456.00	0.00	0.00	0.00	0.00
614	2324228000246	04/02/23 - 04/12/23	09/16/24	6,222.02	0.00	0.00	0.00	0.00
TOTAL				108,839.02	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,227,441.16	ADJUSTMENTS	0.00
COVERED CHARGES	1,221,774.16	CONTRACTUAL ALLOW	993,247.26
NON-COVERD CHARGES	5,667.00	TOTAL MEDICAID LIAB	228,526.90
		LESS: COB	228,715.90
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	189.00
		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	83	0	185,671.00	0.00
ROUTINE NURSERY	17	0	71,424.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	100	0	257,095.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	13,720.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	13,720.00	0.00
TOTAL ACCOMODATIONS	102	0	270,815.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,547.16	0.00	OTHER LAB	2,455.00	0.00
MED/SURG SUPPLY	38,899.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	173,268.00	0.00	EDUCATION & TRAINING	176.00	0.00
RADIOLOGY-DIAGNOSTIC	11,552.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,004.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,924.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,765.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,951.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	221,560.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,215.00	279.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,155.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,851.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	25,587.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,937.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,201.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,631.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,262.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	663.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,621.34	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	7,018.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,169.00	5,388.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,990.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,557.00	0.00			

TOTAL ANCILLARY	950,959.16	5,667.00
TOTAL ACCOMODATIONS	270,815.00	0.00
TOTAL CHARGES	1,221,774.16	5,667.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,092,296.75	ADJUSTMENTS	286,492.63
COVERED CHARGES	22,538,937.82	CONTRACTUAL ALLOW	19,693,663.98
NON-COVERD CHARGES	6,553,358.93	TOTAL MEDICAID LIAB	2,845,273.84
		LESS: COB	13,932.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,831,341.75
		ALL OTHER	2,490,125.79
		FEE SCHEDULE-LAB	257,462.59
		INJECTABLE DRUGS	83,753.37

TOTAL NUMBER OF CLAIMS 4,222

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322,342.77	1,622.40
MED/SURG SUPPLY	721,853.08	1,203,754.23
LABORATORY-GENERAL	0.00	360.00
RADIOLOGY-DIAGNOSTIC	698,771.00	11,524.00
CT SCAN	2,959,297.00	625,776.07
PHYSICAL THERAPY	58,853.00	34,881.00
EKG/ECG	435,764.00	22,673.00
IV THERAPY	1,165,355.00	141,345.00
OPERATING ROOM	1,137,598.64	360,767.36
LABOR/DELIVERY ROOM	2,586.00	0.00
RESPIRATORY SERVICES	138,255.00	30,275.00
ANESTHESIA	185,147.00	0.00
GI SERVICES	408,131.00	245,627.00
EMERGENCY ROOM	3,902,969.00	2,160.00
RECOVERY ROOM	279,101.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,070,355.00	88,737.00
OCCUPATIONAL THERAPY	5,721.00	26,714.00
SPEECH PATHOLOGY	5,110.00	10,924.00
RENAL DIALYSIS	0.00	196,210.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	310.00	2,317.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	2,484.00
OTHER IMAGING SERVICE	428,999.00	78,667.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	207,645.00	28,152.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	63,989.00	213,595.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	847,570.00	1,120,151.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	481,923.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,430,184.35	41,907.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	280,304.00	1,986.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	704.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,397,195.33	445,684.00
MRI SERVICES	197,651.00	229,210.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	262.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	609,183.64	584,434.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	90,978.01	703,785.49
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	5,796.00	96,670.00

TOTAL ANCILLARY	22,538,937.82	6,553,358.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,538,937.82	6,553,358.93

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022192017149	07/05/22 - 07/05/22	07/18/22	0.00	4,843.00	0.00	0.00	0.00
614	2022192017149	07/05/22 - 07/05/22	07/18/22	0.00	426.00	0.00	0.00	0.00
614	2022206019047	07/19/22 - 07/19/22	08/01/22	0.00	4,843.00	0.00	0.00	0.00
614	2022206019047	07/19/22 - 07/19/22	08/01/22	0.00	426.00	0.00	0.00	0.00
614	2022223045167	08/05/22 - 08/05/22	08/15/22	0.00	4,843.00	0.00	0.00	0.00
614	2022223045167	08/05/22 - 08/05/22	08/15/22	0.00	426.00	0.00	0.00	0.00
614	2022236042270	08/18/22 - 08/18/22	08/29/22	0.00	4,843.00	0.00	0.00	0.00
614	2022236042270	08/18/22 - 08/18/22	08/29/22	0.00	426.00	0.00	0.00	0.00
614	2022292066088	10/11/22 - 10/11/22	10/24/22	0.00	4,843.00	0.00	0.00	0.00
614	2022292066088	10/11/22 - 10/11/22	10/24/22	0.00	426.00	0.00	0.00	0.00
614	2022333022637	11/21/22 - 11/21/22	12/05/22	0.00	4,843.00	0.00	0.00	0.00
614	2022333022637	11/21/22 - 11/21/22	12/05/22	0.00	426.00	0.00	0.00	0.00
614	2022355048810	12/07/22 - 12/07/22	12/26/22	0.00	5,796.00	0.00	0.00	0.00
614	2022355048810	12/07/22 - 12/07/22	12/26/22	0.00	426.00	0.00	0.00	0.00
614	2023007020345	12/30/22 - 12/30/22	01/16/23	0.00	5,796.00	0.00	0.00	0.00
614	2023007020345	12/30/22 - 12/30/22	01/16/23	0.00	426.00	0.00	0.00	0.00
614	2023021019739	01/16/23 - 01/16/23	01/30/23	0.00	5,796.00	0.00	0.00	0.00
614	2023021019739	01/16/23 - 01/16/23	01/30/23	0.00	426.00	0.00	0.00	0.00
614	2023075042416	03/07/23 - 03/07/23	03/20/23	0.00	5,796.00	0.00	0.00	0.00
614	2023075042416	03/07/23 - 03/07/23	03/20/23	0.00	426.00	0.00	0.00	0.00
614	2023075042420	03/06/23 - 03/06/23	03/20/23	0.00	5,796.00	0.00	0.00	0.00
614	2023075042420	03/06/23 - 03/06/23	03/20/23	0.00	426.00	0.00	0.00	0.00
614	2023076074081	03/10/23 - 03/10/23	03/20/23	0.00	4,843.00	0.00	0.00	0.00
614	2023076074081	03/10/23 - 03/10/23	03/20/23	0.00	426.00	0.00	0.00	0.00
614	2023088033986	03/22/23 - 03/22/23	04/03/23	0.00	4,843.00	0.00	0.00	0.00
614	2023088033986	03/22/23 - 03/22/23	04/03/23	0.00	426.00	0.00	0.00	0.00
614	2023095049235	03/02/23 - 03/02/23	04/10/23	0.00	4,843.00	0.00	0.00	0.00
614	2023095049235	03/02/23 - 03/02/23	04/10/23	0.00	426.00	0.00	0.00	0.00
614	2023161025929	06/02/23 - 06/02/23	06/19/23	0.00	4,843.00	0.00	0.00	0.00
614	2023161025929	06/02/23 - 06/02/23	06/19/23	0.00	426.00	0.00	0.00	0.00
614	2023193055632	06/29/23 - 06/29/23	07/17/23	0.00	5,796.00	0.00	0.00	0.00
614	2023193055632	06/29/23 - 06/29/23	07/17/23	0.00	426.00	0.00	0.00	0.00
614	2023193056191	06/30/23 - 06/30/23	07/17/23	0.00	5,796.00	0.00	0.00	0.00
614	2023193056191	06/30/23 - 06/30/23	07/17/23	0.00	426.00	0.00	0.00	0.00
614	2223198002465	06/14/23 - 06/14/23	07/24/23	5,796.00	0.00	0.00	0.00	826.78
614	2223198002465	06/14/23 - 06/14/23	07/24/23	0.00	426.00	0.00	0.00	0.00
-1	5023201951041	01/31/23 - 01/01/00	07/24/23	0.00	0.00	0.00	0.00	0.00
TOTAL				5,796.00	96,670.00	0.00	0.00	826.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	565,887.03	ADJUSTMENTS	0.00
COVERED CHARGES	356,754.49	CONTRACTUAL ALLOW	312,753.75
NON-COVERD CHARGES	209,132.54	TOTAL MEDICAID LIAB	44,000.74
		LESS: COB	44,000.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 59

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,888.24	848.65
MED/SURG SUPPLY	13,487.73	797.11
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,825.00	0.00
CT SCAN	22,050.00	6,347.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,871.00	0.00
IV THERAPY	16,354.00	1,671.00
OPERATING ROOM	18,513.00	59,395.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	8,792.00	0.00
GI SERVICES	3,941.00	4,944.00
EMERGENCY ROOM	29,136.00	0.00
RECOVERY ROOM	20,827.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	24,290.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	155.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,238.00	6,032.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,793.00	28,740.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	31,048.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,614.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,191.00	5,862.00
MRI SERVICES	0.00	9,675.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	83,895.52	79,396.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	5,269.00

TOTAL ANCILLARY	356,754.49	209,132.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	356,754.49	209,132.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023103041256	02/21/23 - 02/21/23	04/17/23	0.00	426.00	0.00	7.49	0.00
614	2023103041256	02/21/23 - 02/21/23	04/17/23	0.00	4,843.00	0.00	7.49	0.00
TOTAL				0.00	5,269.00	0.00	14.98	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,966,714.10	ADJUSTMENTS	402.78
COVERED CHARGES	1,905,389.18	CONTRACTUAL ALLOW	1,874,576.51
NON-COVERD CHARGES	61,324.92	TOTAL MEDICAID LIAB	30,812.67
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	30,812.67

TOTAL NUMBER OF CLAIMS 459

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,546.95	83.20
MED/SURG SUPPLY	278.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,344.00	2,895.00
CT SCAN	450,111.00	18,843.01
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	51,982.00	1,106.00
IV THERAPY	170,813.00	17,818.00
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	857,919.00	309.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	24,526.00	2,492.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,298.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	239,943.00	6,112.00
MRI SERVICES	7,774.00	4,404.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,475.23	7,262.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,905,389.18	61,324.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,905,389.18	61,324.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,318.33	ADJUSTMENTS	0.00
COVERED CHARGES	42,749.73	CONTRACTUAL ALLOW	42,279.82
NON-COVERD CHARGES	4,568.60	TOTAL MEDICAID LIAB	469.91
		LESS: COB	469.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177.73	166.40
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,461.00	0.00
CT SCAN	6,756.00	2,893.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,659.00	0.00
IV THERAPY	5,929.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,376.00	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 SERVICE	1,117.00	1,246.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,074.00	180.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	200.00	83.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	42,749.73	4,568.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,749.73	4,568.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,018,508.45	ADJUSTMENTS	79,507.38
COVERED CHARGES	4,719,619.36	CONTRACTUAL ALLOW	4,250,590.45
NON-COVERD CHARGES	1,298,889.09	TOTAL MEDICAID LIAB	469,028.91
		LESS: COB	3,146.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	465,882.54

TOTAL NUMBER OF CLAIMS 83

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,116.75	83.20
MED/SURG SUPPLY	349,528.64	186,306.86
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,748.00	23,258.00
CT SCAN	11,142.00	3,447.00
PHYSICAL THERAPY	0.00	5,445.00
EKG/ECG	5,530.00	553.00
IV THERAPY	16,103.00	0.00
OPERATING ROOM	1,351,819.37	46,797.63
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,215.00	0.00
ANESTHESIA	170,936.00	0.00
GI SERVICES	83,849.00	31,913.00
EMERGENCY ROOM	12,440.00	0.00
RECOVERY ROOM	208,558.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	186,319.00	35,277.00
OCCUPATIONAL THERAPY	0.00	1,666.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	18,740.00	2,578.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	5,884.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,260.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	679,480.00	362,181.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,748.76	1,239.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,953.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	71,450.00	2,913.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,327,173.08	46,476.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	111,509.76	542,870.65
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,719,619.36	1,298,889.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,719,619.36	1,298,889.09

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	407,502.82	ADJUSTMENTS	0.00
COVERED CHARGES	182,627.38	CONTRACTUAL ALLOW	165,699.64
NON-COVERD CHARGES	224,875.44	TOTAL MEDICAID LIAB	16,927.74
		LESS: COB	16,927.74
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,528.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44,556.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	673.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	611.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,108.32	41,760.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,394.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	69,627.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,129.39	10,236.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	172,878.66
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	182,627.38	224,875.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	182,627.38	224,875.44

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	121,642.47	ADJUSTMENTS	0.00
COVERED CHARGES	121,642.47	CONTRACTUAL ALLOW	86,568.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	35,073.77
		LESS: COB	492.33
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	34,581.44

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	7,916.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14	0	7,916.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	1,551.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	1,551.00	0.00
TOTAL ACCOMODATIONS	16	0	9,467.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,598.60	0.00
MED/SURG SUPPLY	817.45	0.00
LABORATORY-GENERAL	39,256.00	0.00
RADIOLOGY-DIAGNOSTIC	1,401.00	0.00
CT SCAN	4,058.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,382.00	0.00
IV THERAPY	2,282.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,900.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,619.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	115.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	514.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,505.62	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,901.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	1,630.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,736.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	459.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	112,175.47	0.00
TOTAL ACCOMODATIONS	9,467.00	0.00
TOTAL CHARGES	121,642.47	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,177,808.77	ADJUSTMENTS	123,355.83
COVERED CHARGES	7,825,761.02	CONTRACTUAL ALLOW	6,876,766.11
NON-COVERD CHARGES	352,047.75	TOTAL MEDICAID LIAB	948,994.91
		LESS: COB	820.72
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	948,174.19
		ALL OTHER	844,439.32
		FEE SCHEDULE-LAB	98,332.81
		INJECTABLE DRUGS	5,402.06

TOTAL NUMBER OF CLAIMS 1,738

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,393.20	0.00
MED/SURG SUPPLY	120,981.05	271.75
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	530,889.00	6,130.00
CT SCAN	1,373,539.00	149,605.00
PHYSICAL THERAPY	0.00	172.00
EKG/ECG	148,199.00	1,380.00
IV THERAPY	281,085.00	31,897.00
OPERATING ROOM	29,743.50	8,604.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,152.00	4,202.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,189,644.00	2,007.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	602.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	108,289.00	2,841.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	66,683.00	12,694.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,007.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	30,127.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	40,878.32	234.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	42,163.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	279,838.00	35,732.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,382,718.65	35,043.05
MRI SERVICES	54,430.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79,280.80	46,735.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	12,636.00
IMPL DEV CHARGE PATIENTS	459.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,261.00	1,261.00

TOTAL ANCILLARY	7,825,761.02	352,047.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,825,761.02	352,047.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023038044539	02/02/23 - 02/02/23	02/13/23	1,261.00	0.00	0.00	0.00	164.94
615	5923250000085	07/20/23 - 07/20/23	09/11/23	0.00	1,261.00	0.00	0.00	0.00
TOTAL				1,261.00	1,261.00	0.00	0.00	164.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,499.20	ADJUSTMENTS	0.00
COVERED CHARGES	151,880.95	CONTRACTUAL ALLOW	133,754.67
NON-COVERD CHARGES	13,618.25	TOTAL MEDICAID LIAB	18,126.28
		LESS: COB	18,126.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,928.25	0.00
MED/SURG SUPPLY	2,649.20	6.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,974.00	0.00
CT SCAN	14,580.00	8,271.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,694.00	0.00
IV THERAPY	3,118.00	982.00
OPERATING ROOM	378.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	555.00	384.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	77,438.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	4,336.00	783.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,905.00	436.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,325.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	2,756.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	151,880.95	13,618.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	151,880.95	13,618.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	325,683.43	ADJUSTMENTS	140.00
COVERED CHARGES	322,417.43	CONTRACTUAL ALLOW	314,577.43
NON-COVERD CHARGES	3,266.00	TOTAL MEDICAID LIAB	7,840.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	7,840.00

TOTAL NUMBER OF CLAIMS 112

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	698.55	0.00
MED/SURG SUPPLY	815.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,761.00	0.00
CT SCAN	11,571.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	690.00	0.00
IV THERAPY	5,648.00	968.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	225,547.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	330.68	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	14,222.00	783.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,752.00	1,490.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,381.80	25.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	322,417.43	3,266.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	322,417.43	3,266.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,629.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,609.00	CONTRACTUAL ALLOW	5,539.00
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	879.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,897.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	424.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,319.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	65.00	20.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,609.00	20.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,609.00	20.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	177,442.93	ADJUSTMENTS	13,746.26
COVERED CHARGES	177,442.93	CONTRACTUAL ALLOW	124,246.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	53,196.63
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	53,196.63

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	18,280.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	18,280.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	13	0	18,280.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,309.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,452.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,564.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,486.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,118.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,584.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,970.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,844.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,184.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,797.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,320.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,834.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,700.00	0.00			

TOTAL ANCILLARY	159,162.93	0.00
TOTAL ACCOMODATIONS	18,280.00	0.00
TOTAL CHARGES	177,442.93	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	659,722.34	ADJUSTMENTS	82,114.35
COVERED CHARGES	478,332.71	CONTRACTUAL ALLOW	283,794.62
NON-COVERD CHARGES	181,389.63	TOTAL MEDICAID LIAB	194,538.09
		LESS: COB	169.46
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	194,368.63
		ALL OTHER	185,803.81
		FEE SCHEDULE-LAB	8,083.53
		INJECTABLE DRUGS	481.29

TOTAL NUMBER OF CLAIMS 286

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	635.35	10,463.87
MED/SURG SUPPLY	32,932.95	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,499.87	2,087.11
CT SCAN	34,016.33	84,790.26
PHYSICAL THERAPY	1,785.00	2,283.00
EKG/ECG	7,134.25	2,756.05
IV THERAPY	67,586.02	7,912.12
OPERATING ROOM	24,664.75	25,030.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,213.23	4,948.08
ANESTHESIA	3,216.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	163,861.12	635.22
RECOVERY ROOM	7,662.40	535.60
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,142.00	470.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,582.63	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,693.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,950.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,092.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	69,633.94	10,386.84
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,031.07	29,090.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	478,332.71	181,389.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	478,332.71	181,389.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	116,791.70	ADJUSTMENTS	1,050.00
COVERED CHARGES	103,682.83	CONTRACTUAL ALLOW	98,922.83
NON-COVERD CHARGES	13,108.87	TOTAL MEDICAID LIAB	4,760.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,760.00

TOTAL NUMBER OF CLAIMS 68

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.16	1,013.89
MED/SURG SUPPLY	3,557.65	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,219.94	1,352.28
CT SCAN	0.00	5,901.06
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,567.65	528.00
IV THERAPY	14,219.87	784.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	594.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	61,653.56	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	517.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,665.53	1,051.26
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,189.47	1,961.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	103,682.83	13,108.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,682.83	13,108.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,421.90	ADJUSTMENTS	0.00
COVERED CHARGES	2,414.74	CONTRACTUAL ALLOW	2,344.74
NON-COVERD CHARGES	7.16	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	483.11	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,216.44	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	709.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	7.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,414.74	7.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,414.74	7.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	167,116.77	ADJUSTMENTS	21,729.02
COVERED CHARGES	125,669.58	CONTRACTUAL ALLOW	81,601.25
NON-COVERD CHARGES	41,447.19	TOTAL MEDICAID LIAB	44,068.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	44,068.33

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	981.24	6,299.41
MED/SURG SUPPLY	7,562.19	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,197.08	211.00
CT SCAN	0.00	13,323.68
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,221.10	352.00
IV THERAPY	24,447.49	1,271.54
OPERATING ROOM	8,929.98	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,881.36	6,534.00
ANESTHESIA	350.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,366.62	0.00
RECOVERY ROOM	2,142.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	1,525.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	34,080.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,005.73	867.02
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,504.39	11,063.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	125,669.58	41,447.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	125,669.58	41,447.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,232,615.01	ADJUSTMENTS	2,547,967.07
COVERED CHARGES	87,810,741.68	CONTRACTUAL ALLOW	79,729,339.96
NON-COVERD CHARGES	421,873.33	TOTAL MEDICAID LIAB	8,081,401.72
		LESS: COB	15,556.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,065,845.32

TOTAL NUMBER OF ADMISSIONS 600

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,241	0	2,912,294.67	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,241	0	2,912,294.67	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,821	0	5,159,624.16	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	83	0	1,708,626.38	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,904	0	6,868,250.54	0.00
TOTAL ACCOMODATIONS	4,145	0	9,780,545.21	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,865,671.82	0.00
MED/SURG SUPPLY	2,960,739.55	0.00
LABORATORY-GENERAL	19,846,669.49	9,879.87
RADIOLOGY-DIAGNOSTIC	1,657,996.69	0.00
CT SCAN	7,071,957.87	96,121.05
PHYSICAL THERAPY	1,371,447.42	0.00
EKG/ECG	617,465.56	0.00
IV THERAPY	228,707.14	0.00
OPERATING ROOM	9,456,388.63	1,483.19
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,419,137.96	0.00
ANESTHESIA	1,348,376.10	0.00
GI SERVICES	225,429.53	0.00
EMERGENCY ROOM	2,193,179.47	0.00
RECOVERY ROOM	653,695.34	0.00
LABORATORY PATHOLOGIC	308,240.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,159,480.37	0.00
SPEECH PATHOLOGY	229,573.95	0.00
RENAL DIALYSIS	748,247.74	24,406.98
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	272.28	456.97
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	670,489.27	6,320.16
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	700,412.52	199,132.92
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	516,579.61	38,756.38
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,692,930.23	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	51,883.85	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	70,369.36	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	663,977.21	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	982,087.23	0.11
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	2,891.88	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	5,350.08
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,794,314.92	584.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	28,989.18
IMPL DEV CHARGE PATIENTS	2,278,525.51	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	243,057.43	10,391.84

TOTAL ANCILLARY	78,030,196.47	421,873.33
TOTAL ACCOMODATIONS	9,780,545.21	0.00
TOTAL CHARGES	87,810,741.68	421,873.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023002009093	12/25/22 - 12/28/22	01/09/23	7,106.66	0.00	0.00	0.00	0.00
614	2023013081022	01/08/23 - 01/09/23	01/16/23	8,859.86	0.00	0.00	0.00	0.00
614	2023014034400	12/27/22 - 12/30/22	01/23/23	6,679.26	0.00	0.00	0.00	0.00
614	2023014034411	12/18/22 - 12/20/22	01/23/23	6,679.26	0.00	0.00	0.00	0.00
614	2023024049311	01/10/23 - 01/17/23	01/30/23	6,679.26	0.00	0.00	0.00	0.00
614	2023024049345	12/13/22 - 12/16/22	01/30/23	6,679.26	0.00	0.00	0.00	0.00
614	2023031065431	12/27/22 - 01/14/23	02/06/23	5,048.42	0.00	0.00	0.00	0.00
614	2223054011638	12/22/22 - 01/03/23	02/27/23	8,859.86	0.00	0.00	0.00	0.00
614	2223059008926	01/03/23 - 01/14/23	03/06/23	8,859.86	0.00	0.00	0.00	0.00
614	2223060008253	11/18/22 - 12/14/22	03/06/23	13,284.78	0.00	0.00	0.00	0.00
614	2023086047782	03/17/23 - 03/22/23	04/03/23	6,679.26	0.00	0.00	0.00	0.00
614	2023091036651	02/20/23 - 02/20/23	04/10/23	8,859.86	0.00	0.00	0.00	0.00
614	2023093031963	03/16/23 - 03/22/23	04/10/23	13,284.78	0.00	0.00	0.00	0.00
614	2023096111366	02/02/23 - 02/22/23	04/10/23	17,719.72	0.00	0.00	0.00	0.00
614	2023100031414	03/14/23 - 04/05/23	04/17/23	8,859.86	0.00	0.00	0.00	0.00
614	5923115001315	03/15/23 - 03/20/23	05/01/23	3,757.23	0.00	0.00	0.00	0.00
615	2023131084946	03/02/23 - 03/13/23	05/15/23	10,391.84	0.00	0.00	0.00	0.00
616	2223143000780	02/19/23 - 03/24/23	05/29/23	0.00	10,391.84	0.00	0.00	0.00
614	2023145099499	05/20/23 - 05/22/23	05/29/23	8,859.86	0.00	0.00	0.00	0.00
614	2223181012023	05/10/23 - 05/20/23	07/03/23	6,679.26	0.00	0.00	0.00	0.00
614	2223186011020	05/25/23 - 06/02/23	07/10/23	8,859.86	0.00	0.00	0.00	0.00
614	2223188006998	06/16/23 - 06/24/23	07/10/23	25,470.04	0.00	0.00	0.00	0.00
614	5923202001182	06/26/23 - 07/01/23	07/31/23	6,679.26	0.00	0.00	0.00	0.00
614	2023205025143	04/20/23 - 04/21/23	07/31/23	6,679.26	0.00	0.00	0.00	0.00
614	2223208001604	12/15/22 - 12/17/22	07/31/23	8,859.86	0.00	0.00	0.00	0.00
614	2223240007635	05/03/23 - 05/07/23	09/04/23	6,679.26	0.00	0.00	0.00	0.00
614	2323338000291	06/23/23 - 07/25/23	12/18/23	9,322.48	0.00	0.00	0.00	0.00
614	2024166075393	03/20/23 - 03/22/23	06/17/24	6,679.26	0.00	0.00	0.00	0.00
TOTAL				243,057.43	10,391.84	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,124.96	ADJUSTMENTS	0.00
COVERED CHARGES	33,124.96	CONTRACTUAL ALLOW	26,620.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,504.48
		LESS: COB	6,504.48
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	3,827.25	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	3,827.25	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	3,827.25	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,477.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,649.57	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,260.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	884.65	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,251.01	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,063.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,953.86	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	3,757.23	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,297.71	0.00
TOTAL ACCOMODATIONS	3,827.25	0.00
TOTAL CHARGES	33,124.96	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023227048975	06/28/23 - 07/01/23	08/21/23	3,757.23	0.00	0.00	6,504.48	0.00
TOTAL				3,757.23	0.00	0.00	6,504.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,745,213.33	ADJUSTMENTS	221,925.44
COVERED CHARGES	23,537,098.43	CONTRACTUAL ALLOW	22,341,636.78
NON-COVERD CHARGES	5,208,114.90	TOTAL MEDICAID LIAB	1,195,461.65
		LESS: COB	1,548.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,193,913.21
		ALL OTHER	1,073,708.36
		FEE SCHEDULE-LAB	100,629.16
		INJECTABLE DRUGS	19,575.69

TOTAL NUMBER OF CLAIMS 2,516

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,750.79	50,880.72
MED/SURG SUPPLY	604,475.46	329,217.37
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,182,884.66	69,880.63
CT SCAN	4,620,255.42	1,113,246.20
PHYSICAL THERAPY	489,668.29	262,866.52
EKG/ECG	557,698.04	9,731.15
IV THERAPY	643,512.79	8,499.63
OPERATING ROOM	2,107,174.87	645,533.38
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79,339.12	0.00
ANESTHESIA	697,254.16	0.00
GI SERVICES	81,021.22	72,080.63
EMERGENCY ROOM	3,377,866.58	9,891.54
RECOVERY ROOM	497,298.59	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	6,798.36	0.00
OCCUPATIONAL THERAPY	99,868.51	142,187.98
SPEECH PATHOLOGY	13,710.59	42,930.50
RENAL DIALYSIS	0.00	7,662.84
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	47,996.93	1,802.03
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	107,163.34	0.00
OTHER IMAGING SERVICE	129,764.85	29,534.67
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,208.04	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	315,297.32	93,380.66
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,231,957.23	863,398.08
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,609.83	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	308,396.75	2,543.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	147,797.31	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	4,432.93
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,804,927.40	361,817.61
MRI SERVICES	423,952.23	97,724.02
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	472,049.17	99,352.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	43,483.77
IMPL DEV CHARGE PATIENTS	280,518.00	841,661.52
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	58,882.58	4,374.61

TOTAL ANCILLARY	23,537,098.43	5,208,114.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,537,098.43	5,208,114.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023042030657	02/07/23 - 02/07/23	02/20/23	5,048.42	0.00	0.00	0.00	288.06
614	2023045058529	02/07/23 - 02/07/23	02/20/23	0.00	4,374.61	0.00	0.00	0.00
614	2023119029478	04/25/23 - 04/25/23	05/08/23	10,391.84	0.00	0.00	0.00	592.94
614	2023142034823	05/18/23 - 05/18/23	05/29/23	10,391.84	0.00	0.00	0.00	592.94
614	2023147029132	05/23/23 - 05/23/23	06/05/23	8,859.86	0.00	0.00	0.00	505.53
614	2023168030912	06/13/23 - 06/13/23	06/26/23	8,859.86	0.00	0.00	0.00	505.53
614	5923180001358	04/25/23 - 04/25/23	07/03/23	4,374.61	0.00	0.00	0.00	249.62
614	2023257081759	06/27/23 - 06/27/23	09/18/23	10,956.15	0.00	0.00	0.00	1,261.32
TOTAL				58,882.58	4,374.61	0.00	0.00	3,995.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	325,929.70	ADJUSTMENTS	0.00
COVERED CHARGES	225,093.06	CONTRACTUAL ALLOW	211,729.78
NON-COVERD CHARGES	100,836.64	TOTAL MEDICAID LIAB	13,363.28
		LESS: COB	13,363.28
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,639.35	248.60
MED/SURG SUPPLY	17,235.35	3,070.55
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,457.44	0.00
CT SCAN	9,046.00	64,625.58
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,603.88	0.00
IV THERAPY	2,785.68	0.00
OPERATING ROOM	63,174.92	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	21,330.09	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,573.44	0.00
RECOVERY ROOM	11,190.32	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,348.52	4,348.52
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	25,179.47
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	758.24	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,903.13	1,410.52
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,588.08	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,980.62	437.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	14,478.00	1,515.86
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	225,093.06	100,836.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	225,093.06	100,836.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,199,625.40	ADJUSTMENTS	134.26
COVERED CHARGES	1,038,089.65	CONTRACTUAL ALLOW	1,026,006.25
NON-COVERD CHARGES	161,535.75	TOTAL MEDICAID LIAB	12,083.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	12,083.40

TOTAL NUMBER OF CLAIMS 180

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	677.76	448.93
MED/SURG SUPPLY	1,933.65	1,615.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,236.97	7,547.74
CT SCAN	313,308.89	107,926.86
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	20,730.90	0.00
IV THERAPY	48,267.45	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	371.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	317,128.38	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,998.41	3,311.08
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,901.68	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	244,360.99	37,904.96
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,172.97	2,781.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,038,089.65	161,535.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,038,089.65	161,535.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,073.38	ADJUSTMENTS	0.00
COVERED CHARGES	18,073.38	CONTRACTUAL ALLOW	17,871.99
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	201.39
		LESS: COB	201.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	2,998.55	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,563.06	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,967.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,532.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.49	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	18,073.38	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,073.38	0.00

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,552,158.75	ADJUSTMENTS	50,339.76
COVERED CHARGES	2,943,410.56	CONTRACTUAL ALLOW	2,841,793.22
NON-COVERD CHARGES	608,748.19	TOTAL MEDICAID LIAB	101,617.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	101,617.34

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,826.02	2,183.01
MED/SURG SUPPLY	59,948.54	52,034.04
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,196.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	9,690.90
EKG/ECG	13,753.84	884.65
IV THERAPY	7,892.76	0.00
OPERATING ROOM	1,327,315.51	17,480.46
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	76,460.33	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	103,309.91	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,170.95
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	127.83
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	470,824.74	0.00
AMBULATORY SURGERY	104,042.32	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,239.89	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	42,046.60	1,874.19
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,299.85	4,755.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	690,254.00	512,546.56
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,943,410.56	608,748.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,943,410.56	608,748.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	134,470.79	ADJUSTMENTS	0.00
COVERED CHARGES	131,442.77	CONTRACTUAL ALLOW	125,849.21
NON-COVERD CHARGES	3,028.02	TOTAL MEDICAID LIAB	5,593.56
		LESS: COB	5,593.56
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND PARK HOSPITAL LLC
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,036.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,990.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,390.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,233.34	FEE SCHEDULE LAB	5,773.66	0.00
EKG/ECG	834.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,947.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,551.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,452.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,794.68	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,465.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	131,442.77	3,028.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	131,442.77	3,028.02

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,686,987.36	ADJUSTMENTS	695,068.23
COVERED CHARGES	40,497,936.36	CONTRACTUAL ALLOW	34,430,957.18
NON-COVERD CHARGES	189,051.00	TOTAL MEDICAID LIAB	6,066,979.18
		LESS: COB	114,094.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,394.00
		REIMBURSEMENT	5,955,278.38

TOTAL NUMBER OF ADMISSIONS 674

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,919	0	5,326,950.00	0.00
ROUTINE NURSERY	434	0	1,266,070.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	33.00
TOTAL ROUTINE	3,353	0	6,593,020.00	33.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	376	0	1,999,042.00	0.00
NICU	38	0	238,298.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	414	0	2,237,340.00	0.00
TOTAL ACCOMODATIONS	3,767	0	8,830,360.00	33.00

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,167,028.42	0.00
MED/SURG SUPPLY	601,186.43	0.00
LABORATORY-GENERAL	7,901,387.00	0.00
RADIOLOGY-DIAGNOSTIC	501,384.00	0.00
CT SCAN	3,540,807.04	17,921.00
PHYSICAL THERAPY	359,965.00	0.00
EKG/ECG	483,322.00	0.00
IV THERAPY	725,878.00	0.00
OPERATING ROOM	2,051,188.00	0.00
LABOR/DELIVERY ROOM	271,895.00	0.00
RESPIRATORY SERVICES	2,583,226.00	0.00
ANESTHESIA	262,070.00	0.00
GI SERVICES	407,172.50	0.00
EMERGENCY ROOM	2,037,628.00	0.00
RECOVERY ROOM	440,734.00	0.00
LABORATORY PATHOLOGIC	152,488.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	199,093.00	0.00
SPEECH PATHOLOGY	101,574.00	0.00
RENAL DIALYSIS	654,775.00	16,818.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,837.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	261,535.00	8,481.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	326,526.00	113,148.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	167,160.07	32,620.00
AUDIOLOGY	35,490.00	0.00
CARDIOLOGY	1,742,069.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	77,724.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	333,556.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	376,946.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.34	30.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	578,390.16	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	312,541.40	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	31,667,576.36	189,018.00
TOTAL ACCOMODATIONS	8,830,360.00	33.00
TOTAL CHARGES	40,497,936.36	189,051.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	696,223.58	ADJUSTMENTS	0.00
COVERED CHARGES	696,223.58	CONTRACTUAL ALLOW	611,290.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	84,933.09
		LESS: COB	85,185.09
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	252.00
		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	16	0	29,184.00	0.00
ROUTINE NURSERY	93	0	276,905.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	109	0	306,089.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	109	0	306,089.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,006.94	0.00	OTHER LAB	620.00	0.00
MED/SURG SUPPLY	11,390.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,601.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,083.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,106.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,671.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,539.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,628.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,556.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,634.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,482.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,110.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,265.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,285.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,070.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,107.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,313.84	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	8,475.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	462.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,028.00	0.00			
CARDIOLOGY	6,051.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,650.00	0.00			

TOTAL ANCILLARY	390,134.58	0.00
TOTAL ACCOMODATIONS	306,089.00	0.00
TOTAL CHARGES	696,223.58	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,892,926.30	ADJUSTMENTS	349,488.74
COVERED CHARGES	16,267,769.11	CONTRACTUAL ALLOW	14,331,591.88
NON-COVERD CHARGES	2,625,157.19	TOTAL MEDICAID LIAB	1,936,177.23
		LESS: COB	6,519.22
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,929,658.01
		ALL OTHER	1,391,776.64
		FEE SCHEDULE-LAB	133,423.35
		INJECTABLE DRUGS	404,458.02

TOTAL NUMBER OF CLAIMS 2,836

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,463.47	854.46
MED/SURG SUPPLY	321,805.89	68,591.73
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	444,000.00	28,099.00
CT SCAN	2,101,898.00	461,662.00
PHYSICAL THERAPY	156,165.00	23,543.00
EKG/ECG	296,408.00	12,166.00
IV THERAPY	956,056.00	126,942.00
OPERATING ROOM	1,107,431.83	179,297.67
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	526,419.00	25,658.00
ANESTHESIA	163,151.00	745.00
GI SERVICES	249,990.00	176,759.00
EMERGENCY ROOM	3,233,846.00	3,605.00
RECOVERY ROOM	267,726.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	51,828.00	6,213.00
OCCUPATIONAL THERAPY	23,041.00	8,186.00
SPEECH PATHOLOGY	25,508.00	17,859.00
RENAL DIALYSIS	0.00	145,756.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	155.00	4,650.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	36,142.00	0.00
OTHER IMAGING SERVICE	455,367.00	61,236.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	55,934.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,353.00	278,457.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	319,053.00	299,506.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	295,549.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	532,193.65	7,766.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	314,229.00	7,194.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	3,185.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,478,911.00	133,078.00
MRI SERVICES	88,623.00	126,698.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,487,792.61	323,767.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	23,729.66	93,682.78
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,267,769.11	2,625,157.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,267,769.11	2,625,157.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	311,160.35	ADJUSTMENTS	0.00
COVERED CHARGES	260,443.91	CONTRACTUAL ALLOW	233,394.41
NON-COVERD CHARGES	50,716.44	TOTAL MEDICAID LIAB	27,049.50
		LESS: COB	27,049.50
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,003.11	582.40
MED/SURG SUPPLY	4,347.78	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,849.00	0.00
CT SCAN	12,051.00	23,376.03
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,977.00	0.00
IV THERAPY	19,519.00	1,864.00
OPERATING ROOM	39,910.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	550.00	0.00
ANESTHESIA	6,594.00	0.00
GI SERVICES	0.00	4,015.00
EMERGENCY ROOM	67,536.00	0.00
RECOVERY ROOM	15,906.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,570.00	4,174.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,701.00	9,317.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,159.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,519.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,267.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,682.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	35,234.00	4,565.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,534.02	1,017.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	1,805.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	260,443.91	50,716.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	260,443.91	50,716.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,224,983.25	ADJUSTMENTS	201.39
COVERED CHARGES	1,183,035.12	CONTRACTUAL ALLOW	1,164,507.24
NON-COVERD CHARGES	41,948.13	TOTAL MEDICAID LIAB	18,527.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	18,527.88

TOTAL NUMBER OF CLAIMS 276

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,684.38	83.20
MED/SURG SUPPLY	163.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,540.00	656.00
CT SCAN	209,170.00	16,674.01
PHYSICAL THERAPY	0.00	535.00
EKG/ECG	29,862.00	3,318.00
IV THERAPY	91,653.00	10,384.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,951.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	527,920.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	790.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	14,251.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,495.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,090.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,199.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	204,415.00	2,009.00
MRI SERVICES	3,887.00	3,887.01
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,754.64	3,611.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,183,035.12	41,948.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,183,035.12	41,948.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,360.65	ADJUSTMENTS	0.00
COVERED CHARGES	32,996.45	CONTRACTUAL ALLOW	32,526.54
NON-COVERD CHARGES	12,364.20	TOTAL MEDICAID LIAB	469.91
		LESS: COB	469.91
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	593.00	0.00
CT SCAN	3,292.00	12,146.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.00	0.00
IV THERAPY	7,751.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,217.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,931.00	135.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	372.95	83.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	32,996.45	12,364.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,996.45	12,364.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,764,643.84	ADJUSTMENTS	26,957.35
COVERED CHARGES	1,542,978.43	CONTRACTUAL ALLOW	1,397,408.74
NON-COVERD CHARGES	221,665.41	TOTAL MEDICAID LIAB	145,569.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	145,569.69

TOTAL NUMBER OF CLAIMS 27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,312.26	0.00
MED/SURG SUPPLY	105,969.88	8,257.45
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,826.00	6,544.00
CT SCAN	4,182.00	0.00
PHYSICAL THERAPY	0.00	1,266.00
EKG/ECG	4,424.00	0.00
IV THERAPY	6,670.00	3,701.00
OPERATING ROOM	644,000.00	29,959.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	643.00	0.00
ANESTHESIA	113,805.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,220.00	0.00
RECOVERY ROOM	126,297.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,674.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,227.00	1,332.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,151.00	2,454.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,501.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,446.50	20,764.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,737.00	3,633.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	248,959.11	32,282.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	58,933.68	111,472.92
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,542,978.43	221,665.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,542,978.43	221,665.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,394,853.28	ADJUSTMENTS	435,739.08
COVERED CHARGES	49,190,289.28	CONTRACTUAL ALLOW	44,301,084.86
NON-COVERD CHARGES	204,564.00	TOTAL MEDICAID LIAB	4,889,204.42
		LESS: COB	74,397.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,268.00
		REIMBURSEMENT	4,817,075.29

TOTAL NUMBER OF ADMISSIONS 609

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,329	0	6,107,470.00	0.00
ROUTINE NURSERY	152	0	434,912.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	7,907.00
TOTAL ROUTINE	2,481	0	6,542,382.00	7,907.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	686	0	3,553,287.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	686	0	3,553,287.00	0.00
TOTAL ACCOMODATIONS	3,167	0	10,095,669.00	7,907.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,400,524.31	0.00
MED/SURG SUPPLY	573,538.69	299.00
LABORATORY-GENERAL	11,547,979.00	0.00
RADIOLOGY-DIAGNOSTIC	949,373.00	0.00
CT SCAN	4,894,040.00	40,482.00
PHYSICAL THERAPY	779,153.00	0.00
EKG/ECG	730,681.00	0.00
IV THERAPY	652,500.00	0.00
OPERATING ROOM	2,509,954.29	13,208.00
LABOR/DELIVERY ROOM	457,877.00	1,707.00
RESPIRATORY SERVICES	2,619,714.00	0.00
ANESTHESIA	921,290.00	0.00
GI SERVICES	127,132.00	0.00
EMERGENCY ROOM	2,075,660.00	0.00
RECOVERY ROOM	595,024.00	0.00
LABORATORY PATHOLOGIC	286,792.00	0.00
RADIOLOGY THERAPEUTIC	37,595.00	0.00
OCCUPATIONAL THERAPY	693,591.00	0.00
SPEECH PATHOLOGY	76,476.00	0.00
RENAL DIALYSIS	667,875.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	19,378.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	553,042.00	20,128.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	216,494.00	95,304.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	324,023.00	25,529.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,614,555.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,318.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	362,553.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	358,388.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	785,921.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	225,860.49	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	10,318.00	0.00

TOTAL ANCILLARY	39,094,620.28	196,657.00
TOTAL ACCOMODATIONS	10,095,669.00	7,907.00
TOTAL CHARGES	49,190,289.28	204,564.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2224152003163	05/10/23 - 06/02/23	06/03/24	10,318.00	0.00	0.00	0.00	0.00
TOTAL				10,318.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	255,318.02	ADJUSTMENTS	0.00
COVERED CHARGES	253,646.02	CONTRACTUAL ALLOW	218,916.55
NON-COVERD CHARGES	1,672.00	TOTAL MEDICAID LIAB	34,729.47
		LESS: COB	34,792.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	13	0	34,406.00	0.00
ROUTINE NURSERY	3	0	7,986.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16	0	42,392.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	13,148.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	13,148.00	0.00
TOTAL ACCOMODATIONS	20	0	55,540.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,720.85	0.00
MED/SURG SUPPLY	1,971.17	0.00
LABORATORY-GENERAL	57,372.00	0.00
RADIOLOGY-DIAGNOSTIC	2,562.00	0.00
CT SCAN	43,336.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,544.00	0.00
IV THERAPY	2,590.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	23,535.00	0.00
RESPIRATORY SERVICES	6,007.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,056.00	0.00
EMERGENCY ROOM	7,330.00	0.00
RECOVERY ROOM	11,064.00	0.00
LABORATORY PATHOLOGIC	2,851.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	934.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	221.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,532.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,884.00	1,672.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,863.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,733.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	198,106.02	1,672.00
TOTAL ACCOMODATIONS	55,540.00	0.00
TOTAL CHARGES	253,646.02	1,672.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER 000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,389,598.36	ADJUSTMENTS	107,844.15
COVERED CHARGES	20,911,529.15	CONTRACTUAL ALLOW	19,609,077.07
NON-COVERD CHARGES	2,478,069.21	TOTAL MEDICAID LIAB	1,302,452.08
		LESS: COB	2,972.44
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,299,479.64
		ALL OTHER	1,158,401.26
		FEE SCHEDULE-LAB	129,492.45
		INJECTABLE DRUGS	11,585.93

TOTAL NUMBER OF CLAIMS 2,465

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,523.01	832.00
MED/SURG SUPPLY	208,069.34	45,935.22
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,013,591.00	16,595.00
CT SCAN	3,980,056.00	615,145.00
PHYSICAL THERAPY	0.00	25,901.00
EKG/ECG	487,176.00	10,176.00
IV THERAPY	743,842.00	105,448.00
OPERATING ROOM	1,246,477.41	226,357.02
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50,409.00	4,048.00
ANESTHESIA	544,368.00	0.00
GI SERVICES	125,224.00	39,836.00
EMERGENCY ROOM	4,083,659.17	2,928.00
RECOVERY ROOM	422,000.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	583,238.00	7,493.00
OCCUPATIONAL THERAPY	0.00	29,330.00
SPEECH PATHOLOGY	0.00	6,847.00
RENAL DIALYSIS	0.00	82,875.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	392.00	4,659.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	510,603.00	35,231.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	36,908.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	68,054.00	309,406.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	849,122.00	255,997.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,875.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	421,864.87	14,956.42

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	193,766.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,647,955.00	278,150.00
MRI SERVICES	354,805.00	131,760.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,753.10
INJECTABLE DRUGS	139,623.26	133,920.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	21,097.94
IMPL DEV CHARGE PATIENTS	45,928.09	70,391.90
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	20,911,529.15	2,478,069.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,911,529.15	2,478,069.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	789,946.49	ADJUSTMENTS	0.00
COVERED CHARGES	136,869.93	CONTRACTUAL ALLOW	128,571.83
NON-COVERD CHARGES	653,076.56	TOTAL MEDICAID LIAB	8,298.10
		LESS: COB	8,298.10
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,651.67	83.20
MED/SURG SUPPLY	465.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,957.00	0.00
CT SCAN	9,666.00	24,517.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,360.00	0.00
IV THERAPY	25,979.00	1,399.00
OPERATING ROOM	5,038.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	35,250.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	703.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,012.00	378.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,173.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	39,829.00	2,730.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,489.26	623,266.36
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	136,869.93	653,076.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,869.93	653,076.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,202,335.31	ADJUSTMENTS	201.39
COVERED CHARGES	2,139,617.01	CONTRACTUAL ALLOW	2,116,859.94
NON-COVERD CHARGES	62,718.30	TOTAL MEDICAID LIAB	22,757.07
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	22,757.07

TOTAL NUMBER OF CLAIMS 339

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,982.04	0.00
MED/SURG SUPPLY	66.00	1,612.67
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	148,912.00	0.00
CT SCAN	608,030.00	21,731.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	54,696.00	5,088.00
IV THERAPY	71,904.00	10,158.00
OPERATING ROOM	5,344.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	279.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	776,281.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	196.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	10,799.00	3,111.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	14,578.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	426,843.00	18,471.00
MRI SERVICES	8,085.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,817.97	2,350.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,139,617.01	62,718.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,139,617.01	62,718.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,935.19	ADJUSTMENTS	0.00
COVERED CHARGES	18,459.20	CONTRACTUAL ALLOW	18,123.55
NON-COVERD CHARGES	8,475.99	TOTAL MEDICAID LIAB	335.65
		LESS: COB	335.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98.80	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,288.00	0.00
CT SCAN	0.00	8,308.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,746.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,585.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,705.00	30.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.40	137.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,459.20	8,475.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,459.20	8,475.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,791,637.32	ADJUSTMENTS	10,747.51
COVERED CHARGES	2,420,006.40	CONTRACTUAL ALLOW	2,287,594.64
NON-COVERD CHARGES	371,630.92	TOTAL MEDICAID LIAB	132,411.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	132,411.76

TOTAL NUMBER OF CLAIMS 25

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,511.09	83.20
MED/SURG SUPPLY	69,945.64	19,429.77
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,785.00	0.00
CT SCAN	7,243.00	0.00
PHYSICAL THERAPY	0.00	21,968.00
EKG/ECG	7,632.00	1,272.00
IV THERAPY	189.00	1,867.00
OPERATING ROOM	914,849.67	18,767.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,606.00	458.00
ANESTHESIA	356,317.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,850.00	0.00
RECOVERY ROOM	289,500.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	10,954.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	196.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,547.00	1,068.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	501,800.00	5,695.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,153.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,802.00	0.00
MRI SERVICES	28,614.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,574.77	34,207.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	81,086.63	255,665.50
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,420,006.40	371,630.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,420,006.40	371,630.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA CARTERSVILLE, LLC
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	221,605,291.84	ADJUSTMENTS	27,462,193.08
COVERED CHARGES	221,099,510.84	CONTRACTUAL ALLOW	159,888,509.42
NON-COVERD CHARGES	505,781.00	TOTAL MEDICAID LIAB	61,211,001.42
		LESS: COB	604,258.37
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	60,606,743.05

TOTAL NUMBER OF ADMISSIONS 2,307

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,166	0	33,840,775.50	0.00
ROUTINE NURSERY	1,955	0	14,940,873.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,121	0	48,781,649.00	0.00
SPECIAL CARE SERVICES				
CCU	53	0	615,674.50	0.00
ICU	0	0	0.00	0.00
NICU	225	0	2,430,799.50	0.00
PED ICU	3,516	0	30,392,887.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,794	0	33,439,361.00	0.00
TOTAL ACCOMODATIONS	16,915	0	82,221,010.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,363,510.00	10,207.50
MED/SURG SUPPLY	3,238,935.89	0.00
LABORATORY-GENERAL	14,755,363.67	6,197.50
RADIOLOGY-DIAGNOSTIC	2,168,933.50	966.50
CT SCAN	2,306,546.00	0.00
PHYSICAL THERAPY	1,297,803.00	0.00
EKG/ECG	99,882.50	0.00
IV THERAPY	1,348,052.00	0.00
OPERATING ROOM	18,232,856.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,663,972.90	0.00
ANESTHESIA	5,429,067.50	0.00
GI SERVICES	11,250.50	0.00
EMERGENCY ROOM	5,210,476.50	0.00
RECOVERY ROOM	691,670.50	0.00
LABORATORY PATHOLOGIC	1,103,065.00	26,714.00
RADIOLOGY THERAPEUTIC	315,547.50	0.00
OCCUPATIONAL THERAPY	980,855.00	0.00
SPEECH PATHOLOGY	619,046.00	0.00
RENAL DIALYSIS	0.00	12,520.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	252.00	10,355.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	535,898.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,819,743.00	30,744.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	31,600.50	31,946.50
AUDIOLOGY	111,682.00	0.00
CARDIOLOGY	1,170,656.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,071,111.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,369,418.50	221,046.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	274,280.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	67,793.50	85,671.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,169,126.50	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	69,411.50
IMPL DEV CHARGE PATIENTS	7,420,104.88	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	138,878,500.84	505,781.00
TOTAL ACCOMODATIONS	82,221,010.00	0.00
TOTAL CHARGES	221,099,510.84	505,781.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,301,423.47	ADJUSTMENTS	0.00
COVERED CHARGES	11,282,176.47	CONTRACTUAL ALLOW	9,352,506.52
NON-COVERD CHARGES	19,247.00	TOTAL MEDICAID LIAB	1,929,669.95
		LESS: COB	1,929,669.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 121

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	415	0	1,205,348.00	0.00
ROUTINE NURSERY	222	0	1,969,323.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	637	0	3,174,671.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	11	0	118,107.00	0.00
PED ICU	91	0	796,684.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	102	0	914,791.00	0.00
TOTAL ACCOMODATIONS	739	0	4,089,462.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,380,680.00	0.00
MED/SURG SUPPLY	207,634.67	0.00
LABORATORY-GENERAL	758,340.12	0.00
RADIOLOGY-DIAGNOSTIC	115,100.00	0.00
CT SCAN	119,215.00	0.00
PHYSICAL THERAPY	38,953.00	0.00
EKG/ECG	2,831.00	0.00
IV THERAPY	2,076.00	0.00
OPERATING ROOM	1,047,358.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	600,819.98	0.00
ANESTHESIA	321,025.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	317,741.00	0.00
RECOVERY ROOM	45,375.00	0.00
LABORATORY PATHOLOGIC	70,471.00	6,678.50
RADIOLOGY THERAPEUTIC	2,685.50	0.00
OCCUPATIONAL THERAPY	44,738.00	0.00
SPEECH PATHOLOGY	22,668.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	27,634.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	87,241.00	1,808.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	8,514.00	0.00
CARDIOLOGY	38,909.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	474,493.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	46,114.50	5,196.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,804.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	9,648.00	5,564.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	94,940.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	293,703.70	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,192,714.47	19,247.00
TOTAL ACCOMODATIONS	4,089,462.00	0.00
TOTAL CHARGES	11,282,176.47	19,247.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	77,420,213.24	ADJUSTMENTS	501,881.60
COVERED CHARGES	71,054,844.39	CONTRACTUAL ALLOW	55,105,483.42
NON-COVERD CHARGES	6,365,368.85	TOTAL MEDICAID LIAB	15,949,360.97
		LESS: COB	75,186.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,874,174.03
		ALL OTHER	13,591,735.52
		FEE SCHEDULE-LAB	692,057.80
		INJECTABLE DRUGS	1,590,380.71

TOTAL NUMBER OF CLAIMS 21,482

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,150,281.75	6,787.75
MED/SURG SUPPLY	1,258,801.14	1.92
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,324,532.00	29,581.00
CT SCAN	2,283,913.50	70,926.00
PHYSICAL THERAPY	1,677,831.00	174,122.00
EKG/ECG	19,029.00	2,787.00
IV THERAPY	1,634,010.50	175,385.00
OPERATING ROOM	8,674,895.28	659,390.72
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	472,633.32	49,327.50
ANESTHESIA	3,548,270.50	5,497.00
GI SERVICES	12,769.50	0.00
EMERGENCY ROOM	8,452,799.43	108,380.00
RECOVERY ROOM	988,394.50	1,503.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	401,939.50	9,545.50
OCCUPATIONAL THERAPY	768,333.00	144,331.00
SPEECH PATHOLOGY	644,836.50	328,327.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,713,726.52	81,168.98
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,079,875.50	51,841.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,089,895.00	28,852.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	95,722.50	13,751.50
AUDIOLOGY	321,779.50	38,785.50
CARDIOLOGY	90,027.50	45,281.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,222,581.50	147,366.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,645,770.39	739,296.61

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	355,287.00	1,429.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	91.00
OTHER THERAPEUTIC SVC	0.00	1,864.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,674,438.78	687,950.17
MRI SERVICES	6,344,629.50	403,161.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,216,796.30	2,323,859.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	34,777.50
IMPL DEV CHARGE PATIENTS	891,043.98	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	71,054,844.39	6,365,368.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	71,054,844.39	6,365,368.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,607,742.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,068,465.51	CONTRACTUAL ALLOW	4,648,662.48
NON-COVERD CHARGES	1,539,276.99	TOTAL MEDICAID LIAB	1,419,803.03
		LESS: COB	1,419,803.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,427

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,611.25	0.00
MED/SURG SUPPLY	127,727.47	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235,538.00	7,636.50
CT SCAN	113,297.00	20,357.50
PHYSICAL THERAPY	66,036.00	7,164.00
EKG/ECG	1,698.00	0.00
IV THERAPY	49,731.00	5,458.00
OPERATING ROOM	1,068,131.50	176,325.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	34,709.51	595.00
ANESTHESIA	539,166.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	582,421.00	3,575.50
RECOVERY ROOM	131,764.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	189,853.00	5,657.00
OCCUPATIONAL THERAPY	11,150.00	1,695.50
SPEECH PATHOLOGY	34,287.50	25,686.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	141,815.50	5,288.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	73,175.50	10,037.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	80,042.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,012.50	3,865.00
AUDIOLOGY	11,102.00	2,573.50
CARDIOLOGY	5,289.50	6,496.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	144,060.00	15,472.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	162,899.50	12,990.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,913.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	469.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	690,728.10	38,704.54
MRI SERVICES	807,280.50	96,821.50
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	445,245.30	1,092,408.95
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	114,779.38	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,068,465.51	1,539,276.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,068,465.51	1,539,276.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,372,226.33	ADJUSTMENTS	268.52
COVERED CHARGES	1,339,907.83	CONTRACTUAL ALLOW	1,305,300.09
NON-COVERD CHARGES	32,318.50	TOTAL MEDICAID LIAB	34,607.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	34,607.74

TOTAL NUMBER OF CLAIMS 517

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,238.00	0.00
MED/SURG SUPPLY	8,380.20	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,291.00	6,087.50
CT SCAN	59,796.50	9,136.00
PHYSICAL THERAPY	2,506.00	564.00
EKG/ECG	0.00	0.00
IV THERAPY	15,739.00	0.00
OPERATING ROOM	4,482.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,150.00	297.50
ANESTHESIA	2,142.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	952,549.50	293.50
RECOVERY ROOM	352.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,471.50	0.00
OCCUPATIONAL THERAPY	0.00	564.00
SPEECH PATHOLOGY	0.00	587.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	611.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	16,871.00	2,653.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,361.00	3,247.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,063.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	121,894.88	5,167.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	66,008.25	1,977.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	1,743.50
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,339,907.83	32,318.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,339,907.83	32,318.50

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	123,087.30	ADJUSTMENTS	0.00
COVERED CHARGES	118,816.80	CONTRACTUAL ALLOW	116,534.38
NON-COVERD CHARGES	4,270.50	TOTAL MEDICAID LIAB	2,282.42
		LESS: COB	2,282.42
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	778.75	0.00
MED/SURG SUPPLY	4,845.49	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,849.50	1,826.00
CT SCAN	16,806.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,822.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	928.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	66,128.00	533.00
RECOVERY ROOM	934.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,977.00	884.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	469.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,481.06	120.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,266.50	437.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	118,816.80	4,270.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,816.80	4,270.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,828,111.02	ADJUSTMENTS	98,761.36
COVERED CHARGES	14,281,732.51	CONTRACTUAL ALLOW	12,429,537.31
NON-COVERD CHARGES	546,378.51	TOTAL MEDICAID LIAB	1,852,195.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,852,195.20

TOTAL NUMBER OF CLAIMS 190

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,480.25	293.50
MED/SURG SUPPLY	138,041.60	0.01
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,487.50	2,376.00
CT SCAN	54,774.00	11,585.00
PHYSICAL THERAPY	0.00	15,873.00
EKG/ECG	0.00	0.00
IV THERAPY	143,926.50	9,684.50
OPERATING ROOM	2,163,043.47	247,023.03
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	42,330.04	6,353.00
ANESTHESIA	862,149.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	58,398.00	2,517.50
RECOVERY ROOM	123,404.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	33,608.00	0.00
OCCUPATIONAL THERAPY	0.00	1,526.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	16,121.00	1,808.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,186.50	1,082.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	37,849.50	4,161.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,724.00	1,120.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,323.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	251,032.50	87,545.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,495.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	199,227.81	14,195.02
MRI SERVICES	104,901.00	18,858.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,904,390.30	116,889.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	3,487.00
IMPL DEV CHARGE PATIENTS	3,023,837.54	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	14,281,732.51	546,378.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,281,732.51	546,378.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,200,645.89	ADJUSTMENTS	0.00
COVERED CHARGES	1,180,763.14	CONTRACTUAL ALLOW	1,045,088.88
NON-COVERD CHARGES	19,882.75	TOTAL MEDICAID LIAB	135,674.26
		LESS: COB	135,674.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,950.75	0.00
MED/SURG SUPPLY	598.37	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	236.00	0.00
OPERATING ROOM	94,785.00	13,165.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	23,484.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	6,903.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	11,007.50	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,496.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,897.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,789.50	443.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	748,643.00	6,274.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	274,972.52	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,180,763.14	19,882.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,180,763.14	19,882.75

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,543.95	ADJUSTMENTS	2,369.94
COVERED CHARGES	78,543.95	CONTRACTUAL ALLOW	53,217.15
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	25,326.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,326.80

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	42,000.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14	0	42,000.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	14	0	42,000.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,459.81	0.00
MED/SURG SUPPLY	4,333.14	0.00
LABORATORY-GENERAL	3,400.12	0.00
RADIOLOGY-DIAGNOSTIC	727.78	0.00
CT SCAN	1,873.20	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	172.45	0.00
IV THERAPY	371.49	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,502.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,106.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,877.40	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	576.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	143.16	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	36,543.95	0.00
TOTAL ACCOMODATIONS	42,000.00	0.00
TOTAL CHARGES	78,543.95	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	857,740.92	ADJUSTMENTS	90,492.65
COVERED CHARGES	805,708.38	CONTRACTUAL ALLOW	509,608.52
NON-COVERD CHARGES	52,032.54	TOTAL MEDICAID LIAB	296,099.86
		LESS: COB	706.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	295,393.56
		ALL OTHER	276,709.05
		FEE SCHEDULE-LAB	18,646.83
		INJECTABLE DRUGS	37.68

TOTAL NUMBER OF CLAIMS 496

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,468.53	0.00
MED/SURG SUPPLY	4,961.62	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,660.00	467.30
CT SCAN	77,372.50	6,701.60
PHYSICAL THERAPY	31,600.17	12,236.91
EKG/ECG	8,622.50	0.00
IV THERAPY	25,520.04	453.67
OPERATING ROOM	42,512.06	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,114.13	25,389.96
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	355,085.00	390.82
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	185.28	185.28
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,177.90	505.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	864.60	0.00
AMBULATORY SURGERY	28,720.73	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	29,365.22	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,570.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	286.32
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	91,462.96	4,984.76
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	284.94	430.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,160.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	805,708.38	52,032.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	805,708.38	52,032.54

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,813.62	ADJUSTMENTS	0.00
COVERED CHARGES	3,963.02	CONTRACTUAL ALLOW	2,636.16
NON-COVERD CHARGES	850.60	TOTAL MEDICAID LIAB	1,326.86
		LESS: COB	1,326.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	211.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	171.54	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	766.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	973.00	84.00
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	321.63	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,113.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,963.02	850.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,963.02	850.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	106,647.46	ADJUSTMENTS	420.00
COVERED CHARGES	102,646.95	CONTRACTUAL ALLOW	96,276.95
NON-COVERD CHARGES	4,000.51	TOTAL MEDICAID LIAB	6,370.00
		LESS: COB	9.99
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	6,360.01

TOTAL NUMBER OF CLAIMS 91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,928.54	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,716.59	0.00
CT SCAN	8,717.75	3,373.95
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	517.35	0.00
IV THERAPY	2,114.85	403.80
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	79,672.65	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,942.32	222.76
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	102,646.95	4,000.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	102,646.95	4,000.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,126.80	ADJUSTMENTS	10,537.42
COVERED CHARGES	148,784.99	CONTRACTUAL ALLOW	106,634.77
NON-COVERD CHARGES	341.81	TOTAL MEDICAID LIAB	42,150.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	42,150.22

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,278.18	0.00
MED/SURG SUPPLY	350.72	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132.18	0.00
CT SCAN	766.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	172.45	172.45
IV THERAPY	3,690.98	0.00
OPERATING ROOM	53,808.94	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,444.16	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	65,012.38	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	12,886.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,241.80	169.36
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	148,784.99	341.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,784.99	341.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,056,594.51	ADJUSTMENTS	0.00
COVERED CHARGES	2,056,201.81	CONTRACTUAL ALLOW	1,884,110.65
NON-COVERD CHARGES	392.70	TOTAL MEDICAID LIAB	172,091.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	172,091.16

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	31	0	95,247.04	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	95,247.04	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	31	0	95,247.04	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,583.26	0.00
MED/SURG SUPPLY	13,056.07	0.00
LABORATORY-GENERAL	17,847.20	0.00
RADIOLOGY-DIAGNOSTIC	846.06	0.00
CT SCAN	1,364.02	0.00
PHYSICAL THERAPY	8,632.45	0.00
EKG/ECG	1,034.70	0.00
IV THERAPY	1,030.08	0.00
OPERATING ROOM	1,253,132.92	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	733.10	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,118.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	863.59	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,456.00	392.70
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,394.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,106.46	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	143.16	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,243.57	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,281.17	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	600,088.48	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,960,954.77	392.70
TOTAL ACCOMODATIONS	95,247.04	0.00
TOTAL CHARGES	2,056,201.81	392.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,144,930.25	ADJUSTMENTS	124,773.48
COVERED CHARGES	2,991,040.27	CONTRACTUAL ALLOW	2,474,891.72
NON-COVERD CHARGES	153,889.98	TOTAL MEDICAID LIAB	516,148.55
		LESS: COB	2,053.61
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	514,094.94
		ALL OTHER	478,672.42
		FEE SCHEDULE-LAB	35,228.55
		INJECTABLE DRUGS	193.97

TOTAL NUMBER OF CLAIMS 921

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,207.41	372.30
MED/SURG SUPPLY	7,268.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,145.54	1,283.28
CT SCAN	168,251.93	35,426.65
PHYSICAL THERAPY	22,190.28	1,913.77
EKG/ECG	22,590.95	517.35
IV THERAPY	40,815.43	4,743.45
OPERATING ROOM	512,145.32	33,535.08
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,925.79	236.50
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	684,157.03	687.80
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,606.28	486.61
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	488.80	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	15,570.66	1,140.84
BLOOD	1,456.00	0.00
BLOOD STORAGE & PRO.	3,754.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,242.20	0.00
AMBULATORY SURGERY	1,048.44	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	922,732.54	48,537.60

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	22,645.50	1,000.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	190.88
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	332,393.86	14,979.12
MRI SERVICES	77,719.46	2,878.75
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,065.46	160.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	18,617.84	5,800.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,991,040.27	153,889.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,991,040.27	153,889.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	89,182.98	ADJUSTMENTS	0.00
COVERED CHARGES	68,612.04	CONTRACTUAL ALLOW	57,569.42
NON-COVERD CHARGES	20,570.94	TOTAL MEDICAID LIAB	11,042.62
		LESS: COB	11,042.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,044.68	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,531.36	0.00
CT SCAN	2,759.19	5,463.29
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,034.70	172.45
IV THERAPY	1,230.16	0.00
OPERATING ROOM	24,268.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	133.16	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,344.75	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,067.20	12,134.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,131.76	250.80
MRI SERVICES	1,946.28	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	120.00	2,550.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	68,612.04	20,570.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	68,612.04	20,570.94

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	193,955.05	ADJUSTMENTS	210.00
COVERED CHARGES	185,904.41	CONTRACTUAL ALLOW	177,364.41
NON-COVERD CHARGES	8,050.64	TOTAL MEDICAID LIAB	8,540.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,540.00

TOTAL NUMBER OF CLAIMS 122

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,236.97	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,485.10	381.24
CT SCAN	5,942.58	5,560.38
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	689.80	0.00
IV THERAPY	2,580.24	95.28
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	133.16	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	138,954.06	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	697.38	576.78
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,185.12	1,436.96
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	185,904.41	8,050.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,904.41	8,050.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,971.16	ADJUSTMENTS	0.00
COVERED CHARGES	16,947.16	CONTRACTUAL ALLOW	16,597.16
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	350.00
		LESS: COB	350.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253.55	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	353.82	0.00
CT SCAN	4,260.41	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	172.45	0.00
IV THERAPY	604.98	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,288.75	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,013.20	24.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	16,947.16	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,947.16	24.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,659,605.88	ADJUSTMENTS	10,300.94
COVERED CHARGES	1,620,682.39	CONTRACTUAL ALLOW	1,507,372.05
NON-COVERD CHARGES	38,923.49	TOTAL MEDICAID LIAB	113,310.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	113,310.34

TOTAL NUMBER OF CLAIMS 22

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,247.10	0.00
MED/SURG SUPPLY	10,784.21	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	343.08	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	1,696.71
EKG/ECG	0.00	862.25
IV THERAPY	0.00	0.00
OPERATING ROOM	888,361.68	34,886.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	325.68	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	11,980.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	389.17
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	79,433.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	95.44
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,581.44	358.72
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	460.00	634.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	609,165.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,620,682.39	38,923.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,620,682.39	38,923.49

TATTNALL HOSPITAL COMPANY, LLC
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,150.10	ADJUSTMENTS	0.00
COVERED CHARGES	32,150.10	CONTRACTUAL ALLOW	23,301.08
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,849.02
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,849.02

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	5,250.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9	0	5,250.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	9	0	5,250.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,061.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,645.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,538.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,155.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	480.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	370.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,094.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,768.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,201.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	826.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	370.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	630.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,526.10	0.00			

TOTAL ANCILLARY	26,900.10	0.00
TOTAL ACCOMODATIONS	5,250.00	0.00
TOTAL CHARGES	32,150.10	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/22	THROUGH	04/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	445,514.87	ADJUSTMENTS	22,789.77
COVERED CHARGES	377,045.71	CONTRACTUAL ALLOW	224,547.15
NON-COVERD CHARGES	68,469.16	TOTAL MEDICAID LIAB	152,498.56
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	152,498.56
		ALL OTHER	136,535.98
		FEE SCHEDULE-LAB	15,422.58
		INJECTABLE DRUGS	540.00

TOTAL NUMBER OF CLAIMS 367

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,204.60	6,487.20
MED/SURG SUPPLY	887.00	6.60
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,333.00	3,840.00
CT SCAN	39,011.03	20,083.00
PHYSICAL THERAPY	2,720.00	960.00
EKG/ECG	6,105.00	0.00
IV THERAPY	20,969.00	942.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,155.00	0.00
ANESTHESIA	3,151.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,721.00	0.00
RECOVERY ROOM	2,760.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	51,113.00	12,695.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,619.00	1,102.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,161.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,575.00	735.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,231.44	161.36

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	11,806.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90,134.00	16,873.00
MRI SERVICES	19,084.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,305.64	4,376.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	208.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	377,045.71	68,469.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	377,045.71	68,469.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,362.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,203.00	CONTRACTUAL ALLOW	2,190.60
NON-COVERD CHARGES	3,159.00	TOTAL MEDICAID LIAB	1,012.40
		LESS: COB	1,012.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,150.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,059.00	9.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	807.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,082.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	160.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,203.00	3,159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,203.00	3,159.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,654.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,432.00	CONTRACTUAL ALLOW	3,012.00
NON-COVERD CHARGES	1,222.00	TOTAL MEDICAID LIAB	420.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	420.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,155.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	713.00	9.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,414.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78.00	53.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,432.00	1,222.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,432.00	1,222.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/22 THROUGH 04/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,641,455.09	ADJUSTMENTS	447,617.32
COVERED CHARGES	22,436,605.88	CONTRACTUAL ALLOW	17,603,508.92
NON-COVERD CHARGES	204,849.21	TOTAL MEDICAID LIAB	4,833,096.96
		LESS: COB	82,497.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,890.00
		REIMBURSEMENT	4,752,489.96

TOTAL NUMBER OF ADMISSIONS 469

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,299	0	2,450,198.00	0.00
ROUTINE NURSERY	135	0	176,133.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,434	0	2,626,331.00	0.00
SPECIAL CARE SERVICES				
CCU	374	0	691,488.00	0.00
ICU	224	0	462,836.00	0.00
NICU	32	0	76,448.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	630	0	1,230,772.00	0.00
TOTAL ACCOMODATIONS	3,064	0	3,857,103.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,291,839.05	0.00
MED/SURG SUPPLY	3,760,800.24	184,642.21
LABORATORY-GENERAL	1,973,057.81	0.00
RADIOLOGY-DIAGNOSTIC	373,144.00	0.00
CT SCAN	1,378,897.00	0.00
PHYSICAL THERAPY	192,020.00	0.00
EKG/ECG	124,408.00	0.00
IV THERAPY	136,361.00	0.00
OPERATING ROOM	1,368,134.00	0.00
LABOR/DELIVERY ROOM	25,530.00	0.00
RESPIRATORY SERVICES	707,548.00	0.00
ANESTHESIA	100,468.00	0.00
GI SERVICES	172,812.00	0.00
EMERGENCY ROOM	787,144.00	0.00
RECOVERY ROOM	72,564.00	0.00
LABORATORY PATHOLOGIC	55,060.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	131,632.00	296.00
SPEECH PATHOLOGY	40,552.00	0.00
RENAL DIALYSIS	213,678.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,735.00	3,992.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	514,306.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	287,078.01	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	68,780.00	2,292.00
AUDIOLOGY	6,550.00	0.00
CARDIOLOGY	832,333.00	2,307.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	28,380.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	316,498.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	134,578.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	15,283.00	0.00
OTHER THERAPEUTIC SVC	26,206.00	11,320.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	226,174.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	3,345.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28,911.82	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	171,639.94	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	7,056.00	0.00

TOTAL ANCILLARY	18,579,502.88	204,849.21
TOTAL ACCOMODATIONS	3,857,103.00	0.00
TOTAL CHARGES	22,436,605.88	204,849.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2023131000108	04/27/23 - 04/30/23	05/15/23	3,528.00	0.00	0.00	0.00	0.00
615	2323326000067	06/02/23 - 06/02/23	12/04/23	3,528.00	0.00	0.00	494.36	0.00
TOTAL				7,056.00	0.00	0.00	494.36	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,326.26	ADJUSTMENTS	0.00
COVERED CHARGES	162,326.26	CONTRACTUAL ALLOW	128,893.13
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	33,433.13
		LESS: COB	33,433.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	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	26	0	25,595.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	26	0	25,595.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	4,778.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	4,778.00	0.00
TOTAL ACCOMODATIONS	28	0	30,373.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,856.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,128.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,110.99	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,132.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,836.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	970.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,018.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,904.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	759.00	0.00	REHAB THERAPY	60.00	0.00
RESPIRATORY SERVICES	10,797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	694.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,340.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	148.20	0.00	INJECTABLE DRUGS	589.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	6,481.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,614.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,671.00	0.00			

TOTAL ANCILLARY	131,953.26	0.00
TOTAL ACCOMODATIONS	30,373.00	0.00
TOTAL CHARGES	162,326.26	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,313,659.86	ADJUSTMENTS	322,770.28
COVERED CHARGES	6,815,373.96	CONTRACTUAL ALLOW	5,282,869.36
NON-COVERD CHARGES	498,285.90	TOTAL MEDICAID LIAB	1,532,504.60
		LESS: COB	5,718.50
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,526,786.10
		ALL OTHER	1,361,945.04
		FEE SCHEDULE-LAB	153,358.82
		INJECTABLE DRUGS	11,482.24

TOTAL NUMBER OF CLAIMS 3,982

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,935.04	2,274.00
MED/SURG SUPPLY	483,410.73	3,844.00
LABORATORY-GENERAL	0.00	102.00
RADIOLOGY-DIAGNOSTIC	276,622.00	1,737.00
CT SCAN	1,189,492.00	104,560.00
PHYSICAL THERAPY	39,307.00	8,478.00
EKG/ECG	130,246.00	1,062.00
IV THERAPY	304,506.00	768.00
OPERATING ROOM	383,418.11	55,789.89
LABOR/DELIVERY ROOM	8,027.00	0.00
RESPIRATORY SERVICES	9,195.00	299.00
ANESTHESIA	36,256.00	0.00
GI SERVICES	52,995.17	28,063.83
EMERGENCY ROOM	789,348.00	2,841.00
RECOVERY ROOM	55,533.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	14,996.00	4,722.00
SPEECH PATHOLOGY	3,559.00	2,837.00
RENAL DIALYSIS	0.00	2,188.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	101,552.00	2,225.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	284,565.00	21,365.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,851.47	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	156,441.00	16,005.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	284,430.00	55,338.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,488.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	68,984.00	189.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	273,481.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,548.00
OTHER THERAPEUTIC SVC	1,392.00	439.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,168,033.38	31,784.06
MRI SERVICES	254,239.00	21,914.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	100.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	5,497.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	144,304.16	112,774.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	1,269.90	15,038.44
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,815,373.96	498,285.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,815,373.96	498,285.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,312.28	ADJUSTMENTS	0.00
COVERED CHARGES	21,058.95	CONTRACTUAL ALLOW	16,830.19
NON-COVERD CHARGES	6,253.33	TOTAL MEDICAID LIAB	4,228.76
		LESS: COB	4,228.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,611.53	0.00
MED/SURG SUPPLY	1,189.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	329.00	0.00
CT SCAN	0.00	5,044.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	878.00	0.00
IV THERAPY	523.00	0.00
OPERATING ROOM	1,636.00	0.00
LABOR/DELIVERY ROOM	442.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	165.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,605.00	0.00
RECOVERY ROOM	870.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,028.00	720.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,263.10	364.04
MRI SERVICES	2,722.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	796.82	125.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	21,058.95	6,253.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,058.95	6,253.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	156,291.16	ADJUSTMENTS	201.39
COVERED CHARGES	141,875.39	CONTRACTUAL ALLOW	136,974.90
NON-COVERD CHARGES	14,415.77	TOTAL MEDICAID LIAB	4,900.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,900.49

TOTAL NUMBER OF CLAIMS 73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,107.30	0.00
MED/SURG SUPPLY	2,559.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,248.00	0.00
CT SCAN	53,460.00	5,044.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,940.00	0.00
IV THERAPY	8,138.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	36,765.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,601.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,473.05	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,227.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,001.21	515.68
MRI SERVICES	0.00	7,350.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,355.83	1,506.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	141,875.39	14,415.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	141,875.39	14,415.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,875.73	ADJUSTMENTS	0.00
COVERED CHARGES	3,733.73	CONTRACTUAL ALLOW	3,599.47
NON-COVERD CHARGES	10,142.00	TOTAL MEDICAID LIAB	134.26
		LESS: COB	134.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	169.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	73.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,088.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,734.80	54.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	255.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,332.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	169.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,733.73	10,142.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,733.73	10,142.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	982,951.93	ADJUSTMENTS	52,847.00
COVERED CHARGES	686,863.61	CONTRACTUAL ALLOW	575,876.80
NON-COVERD CHARGES	296,088.32	TOTAL MEDICAID LIAB	110,986.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	110,986.81

TOTAL NUMBER OF CLAIMS 21

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,434.74	0.00
MED/SURG SUPPLY	197,407.73	153,159.32
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,097.00	5,840.00
CT SCAN	18,111.00	3,844.00
PHYSICAL THERAPY	0.00	3,523.00
EKG/ECG	3,512.00	0.00
IV THERAPY	35,796.00	0.00
OPERATING ROOM	213,392.00	60,911.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	148.00	0.00
ANESTHESIA	14,115.00	0.00
GI SERVICES	0.00	5,602.00
EMERGENCY ROOM	8,779.00	0.00
RECOVERY ROOM	11,902.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,517.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	7,858.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,922.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,721.05	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,345.00	367.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	46,749.00	15,565.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,634.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,087.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	83.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,709.14	984.58
MRI SERVICES	0.00	3,335.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,001.95	18,579.42
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	12,920.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	686,863.61	296,088.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	686,863.61	296,088.32

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,880,055.72	ADJUSTMENTS	262,766.76
COVERED CHARGES	18,692,873.23	CONTRACTUAL ALLOW	14,467,765.93
NON-COVERD CHARGES	187,182.49	TOTAL MEDICAID LIAB	4,225,107.30
		LESS: COB	65,978.36
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,159,128.94

TOTAL NUMBER OF ADMISSIONS 710

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,585	0	1,505,582.00	0.00
ROUTINE NURSERY	212	0	138,470.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.01
TOTAL ROUTINE	1,797	0	1,644,052.00	0.01
SPECIAL CARE SERVICES				
CCU	858	0	1,027,280.00	0.00
ICU	500	0	737,458.00	0.00
NICU	2	0	1,308.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,360	0	1,766,046.00	0.00
TOTAL ACCOMODATIONS	3,157	0	3,410,098.00	0.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,712,210.85	30,569.48
MED/SURG SUPPLY	1,444,883.13	13,276.00
LABORATORY-GENERAL	3,790,945.00	5,487.00
RADIOLOGY-DIAGNOSTIC	229,781.00	0.00
CT SCAN	1,137,314.00	15,799.00
PHYSICAL THERAPY	103,231.00	919.00
EKG/ECG	185,506.00	0.00
IV THERAPY	375,730.48	0.00
OPERATING ROOM	934,742.00	0.00
LABOR/DELIVERY ROOM	240,251.00	0.00
RESPIRATORY SERVICES	607,892.00	0.00
ANESTHESIA	126,898.00	177.00
GI SERVICES	100,247.00	0.00
EMERGENCY ROOM	633,162.00	1,042.00
RECOVERY ROOM	92,766.00	0.00
LABORATORY PATHOLOGIC	47,386.00	0.00
RADIOLOGY THERAPEUTIC	29,768.00	0.00
OCCUPATIONAL THERAPY	42,476.00	0.00
SPEECH PATHOLOGY	33,321.00	0.00
RENAL DIALYSIS	551,636.00	6,218.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	248.00	21,238.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	114,491.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	203,584.00	71,838.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	235,444.00	20,045.00
AUDIOLOGY	18,029.00	0.00
CARDIOLOGY	455,753.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,335.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	113,933.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	83,158.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	682.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	149,582.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,510.77	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	476,879.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	574.00

TOTAL ANCILLARY	15,282,775.23	187,182.48
TOTAL ACCOMODATIONS	3,410,098.00	0.01
TOTAL CHARGES	18,692,873.23	187,182.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
242	2323257000262	07/08/23 - 07/12/23	09/18/23	0.00	350.00	0.00	303.82	0.00
9921	5923310000457	09/16/23 - 09/22/23	11/13/23	0.00	224.00	0.00	0.00	0.00
TOTAL				0.00	574.00	0.00	303.82	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,650.94	ADJUSTMENTS	0.00
COVERED CHARGES	57,650.94	CONTRACTUAL ALLOW	43,525.99
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,124.95
		LESS: COB	14,124.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11	0	9,650.00	0.00
ROUTINE NURSERY	3	0	2,600.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14	0	12,250.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	2,386.00	0.00
ICU	1	0	1,278.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	3,664.00	0.00
TOTAL ACCOMODATIONS	17	0	15,914.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,321.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,736.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,758.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,946.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,946.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,543.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,591.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	189.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,945.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	298.00	0.00			
CARDIOLOGY	2,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,736.94	0.00
TOTAL ACCOMODATIONS	15,914.00	0.00
TOTAL CHARGES	57,650.94	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,406,294.12	ADJUSTMENTS	1,025,965.80
COVERED CHARGES	12,615,114.68	CONTRACTUAL ALLOW	9,666,220.47
NON-COVERD CHARGES	791,179.44	TOTAL MEDICAID LIAB	2,948,894.21
		LESS: COB	5,559.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,943,334.26
		ALL OTHER	1,912,501.54
		FEE SCHEDULE-LAB	311,543.92
		INJECTABLE DRUGS	719,288.80

TOTAL NUMBER OF CLAIMS 5,751

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	276,058.20	1,102.40
MED/SURG SUPPLY	472,964.38	3,267.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	483,867.00	3,397.00
CT SCAN	1,780,634.00	58,485.00
PHYSICAL THERAPY	205,082.00	25,677.00
EKG/ECG	162,056.00	2,780.00
IV THERAPY	464,135.00	13,377.00
OPERATING ROOM	1,010,779.85	84,260.15
LABOR/DELIVERY ROOM	206.00	0.00
RESPIRATORY SERVICES	172,020.00	1,508.00
ANESTHESIA	108,332.00	0.00
GI SERVICES	205,591.34	14,341.66
EMERGENCY ROOM	1,282,244.00	5,986.00
RECOVERY ROOM	113,118.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	136,796.00	8,356.00
OCCUPATIONAL THERAPY	25,260.00	6,691.00
SPEECH PATHOLOGY	10,541.00	755.00
RENAL DIALYSIS	0.00	15,090.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	289,744.00	587.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	27,610.00	0.00
OTHER IMAGING SERVICE	230,118.00	8,903.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	21,202.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	321,406.00	66,251.00
AUDIOLOGY	1,937.00	0.00
CARDIOLOGY	362,122.00	13,416.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,751.00	1,282.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	151,316.00	1,782.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	92,335.00	610.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	120.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,208,812.00	101,979.00
MRI SERVICES	319,848.00	0.00
PROFESSIONAL FEES	0.00	963.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,640,228.91	193,939.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	156,274.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,615,114.68	791,179.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,615,114.68	791,179.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	308,844.60	ADJUSTMENTS	0.00
COVERED CHARGES	190,018.60	CONTRACTUAL ALLOW	151,239.08
NON-COVERD CHARGES	118,826.00	TOTAL MEDICAID LIAB	38,779.52
		LESS: COB	38,779.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,790.71	3,062.02
MED/SURG SUPPLY	21,857.00	557.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,271.00	337.00
CT SCAN	36,674.00	33,165.00
PHYSICAL THERAPY	0.00	643.00
EKG/ECG	3,248.00	0.00
IV THERAPY	9,221.00	0.00
OPERATING ROOM	19,337.00	15,464.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,825.00	0.00
ANESTHESIA	5,829.00	0.00
GI SERVICES	0.00	3,487.00
EMERGENCY ROOM	19,162.00	122.00
RECOVERY ROOM	3,896.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	111.00	486.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,710.00	62.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,873.00	1,016.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,234.00	15,935.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,664.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	781.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,683.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	295.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	31,564.00	2,241.00
MRI SERVICES	7,531.00	6,936.00
PROFESSIONAL FEES	0.00	1,139.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,461.89	10,413.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	23,760.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	190,018.60	118,826.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190,018.60	118,826.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	360,065.44	ADJUSTMENTS	548.24
COVERED CHARGES	353,639.42	CONTRACTUAL ALLOW	337,192.22
NON-COVERD CHARGES	6,426.02	TOTAL MEDICAID LIAB	16,447.20
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	16,447.20

TOTAL NUMBER OF CLAIMS 210

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,723.08	2.77
MED/SURG SUPPLY	11,224.00	434.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,669.00	671.00
CT SCAN	72,059.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,560.00	0.00
IV THERAPY	21,112.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,492.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	127,573.00	277.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	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	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,516.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,698.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,140.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	66,710.00	2,315.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,163.34	2,664.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	353,639.42	6,426.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	353,639.42	6,426.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,613.86	ADJUSTMENTS	0.00
COVERED CHARGES	18,459.82	CONTRACTUAL ALLOW	18,068.22
NON-COVERD CHARGES	4,154.04	TOTAL MEDICAID LIAB	391.60
		LESS: COB	391.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379.22	512.27
MED/SURG SUPPLY	318.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	9,266.00	2,466.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	990.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,945.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,002.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,485.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,974.00	38.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	102.60	135.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,459.82	4,154.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,459.82	4,154.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,158,796.01	ADJUSTMENTS	85,232.16
COVERED CHARGES	1,058,867.25	CONTRACTUAL ALLOW	864,969.55
NON-COVERD CHARGES	99,928.76	TOTAL MEDICAID LIAB	193,897.70
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	193,897.70

TOTAL NUMBER OF CLAIMS 41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,821.63	0.00
MED/SURG SUPPLY	62,076.00	125.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,594.00	13,390.00
CT SCAN	23,571.00	2,466.00
PHYSICAL THERAPY	0.00	594.00
EKG/ECG	4,360.00	556.00
IV THERAPY	16,442.00	0.00
OPERATING ROOM	214,003.00	1,248.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,532.00	139.00
ANESTHESIA	28,250.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,157.00	282.00
RECOVERY ROOM	13,411.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	127,950.00	0.00
OCCUPATIONAL THERAPY	0.00	870.00
SPEECH PATHOLOGY	0.00	742.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	29,150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	711.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,628.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	37,016.00	2,836.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,929.00	3,341.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	43,129.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,057.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,434.00	2,241.00
MRI SERVICES	3,452.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	350,193.62	8,575.76
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	62,523.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,058,867.25	99,928.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,058,867.25	99,928.76

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,024.53	ADJUSTMENTS	0.00
COVERED CHARGES	51,350.20	CONTRACTUAL ALLOW	41,857.94
NON-COVERD CHARGES	9,674.33	TOTAL MEDICAID LIAB	9,492.26
		LESS: COB	9,492.26
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 SOUTH MAIN ST
MOULTRIE,GA 31776-0040

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,558.71	296.02	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,782.00	288.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	971.00	91.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,909.00	785.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,601.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	330.49	1,088.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	7,126.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	51,350.20	9,674.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,350.20	9,674.33

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,041,785.54	ADJUSTMENTS	29,984.82
COVERED CHARGES	5,004,804.54	CONTRACTUAL ALLOW	4,055,826.45
NON-COVERD CHARGES	36,981.00	TOTAL MEDICAID LIAB	948,978.09
		LESS: COB	21,258.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	927,719.49

TOTAL NUMBER OF ADMISSIONS 127

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	329	0	559,629.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	329	0	559,629.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	66	0	193,974.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	66	0	193,974.00	0.00
TOTAL ACCOMODATIONS	395	0	753,603.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,044,075.00	25,084.00	OTHER LAB	29,257.00	0.00
MED/SURG SUPPLY	4,432.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	843,742.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,653.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	553,160.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,400.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	64,236.00	0.00	MRI SERVICES	76,691.00	0.00
IV THERAPY	432,273.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,318.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181,727.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,854.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	356,684.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,338.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,872.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,382.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,235.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	423.00	337.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,376.54	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	21,738.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,578.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	63,026.00	11,560.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	199,367.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	177,364.00	0.00			

TOTAL ANCILLARY	4,251,201.54	36,981.00
TOTAL ACCOMODATIONS	753,603.00	0.00
TOTAL CHARGES	5,004,804.54	36,981.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,753.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,753.00	CONTRACTUAL ALLOW	27,679.41
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,073.59
		LESS: COB	5,073.59
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	5,103.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	5,103.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	5,103.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,958.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,037.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	352.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	290.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	404.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,058.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	141.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,633.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,068.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,650.00	0.00
TOTAL ACCOMODATIONS	5,103.00	0.00
TOTAL CHARGES	32,753.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,272,316.13	ADJUSTMENTS	101,355.06
COVERED CHARGES	8,118,168.27	CONTRACTUAL ALLOW	7,062,972.33
NON-COVERD CHARGES	1,154,147.86	TOTAL MEDICAID LIAB	1,055,195.94
		LESS: COB	1,966.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,053,229.34
		ALL OTHER	912,529.39
		FEE SCHEDULE-LAB	89,221.06
		INJECTABLE DRUGS	51,478.89

TOTAL NUMBER OF CLAIMS 1,744

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,499.00	147,631.00
MED/SURG SUPPLY	70,018.43	42,708.34
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	399,991.00	7,700.00
CT SCAN	1,403,283.00	182,126.00
PHYSICAL THERAPY	580.00	2,496.00
EKG/ECG	142,612.00	808.00
IV THERAPY	702,985.00	0.00
OPERATING ROOM	229,551.21	43,750.79
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	395,954.00	27,643.00
ANESTHESIA	120,312.00	504.00
GI SERVICES	7,756.50	2,585.50
EMERGENCY ROOM	2,133,321.00	2,709.00
RECOVERY ROOM	152,082.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	326.00	1,054.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	23,488.00	987.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	153,082.00	14,402.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	45,943.00	810.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,751.00	24,060.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	109,191.00	11,482.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	179,561.00	17,585.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	99,848.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,149,980.00	143,606.00
MRI SERVICES	181,149.00	26,746.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	370,249.00	211,710.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	873.13	241,043.93
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	1,782.00	0.00

TOTAL ANCILLARY	8,118,168.27	1,154,147.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,118,168.27	1,154,147.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2023031051706	01/21/23 - 01/21/23	02/06/23	1,782.00	0.00	0.00	0.00	249.62
TOTAL				1,782.00	0.00	0.00	0.00	249.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	190,732.00	ADJUSTMENTS	0.00
COVERED CHARGES	151,670.60	CONTRACTUAL ALLOW	133,786.99
NON-COVERD CHARGES	39,061.40	TOTAL MEDICAID LIAB	17,883.61
		LESS: COB	17,883.61
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	3,778.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,038.00	0.00
CT SCAN	5,158.00	17,553.00
PHYSICAL THERAPY	0.00	424.00
EKG/ECG	3,636.00	0.00
IV THERAPY	17,639.00	0.00
OPERATING ROOM	7,177.60	1,794.40
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,460.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	56,341.00	0.00
RECOVERY ROOM	6,187.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	594.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	760.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,810.00	3,266.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,633.00	1,029.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,100.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,753.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,968.00	2,150.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,010.00	8,473.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	151,670.60	39,061.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	151,670.60	39,061.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,980.00	ADJUSTMENTS	0.00
COVERED CHARGES	110,228.00	CONTRACTUAL ALLOW	105,931.68
NON-COVERD CHARGES	752.00	TOTAL MEDICAID LIAB	4,296.32
		LESS: COB	60.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,236.32

TOTAL NUMBER OF CLAIMS 64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	339.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,356.00	0.00
CT SCAN	2,436.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	808.00	0.00
IV THERAPY	3,358.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	83,554.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	141.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,097.00	291.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,478.00	122.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	110,228.00	752.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	110,228.00	752.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,230.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,230.00	CONTRACTUAL ALLOW	2,162.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	67.13
		LESS: COB	67.13
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	689.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,541.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,230.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,230.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,288,306.99	ADJUSTMENTS	11,144.30
COVERED CHARGES	896,360.50	CONTRACTUAL ALLOW	812,447.10
NON-COVERD CHARGES	391,946.49	TOTAL MEDICAID LIAB	83,913.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	83,913.40

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99.00	28,486.00
MED/SURG SUPPLY	145,263.43	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,731.00	0.00
CT SCAN	15,988.00	5,075.00
PHYSICAL THERAPY	0.00	3,354.00
EKG/ECG	2,828.00	0.00
IV THERAPY	16,236.00	0.00
OPERATING ROOM	345,000.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,832.00	0.00
ANESTHESIA	142,340.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,769.00	0.00
RECOVERY ROOM	81,571.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,564.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,633.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,318.00	1,426.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,240.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	9,376.00	21,102.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,788.00	1,094.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	53,296.00	28,719.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	38,052.07	299,126.49
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	896,360.50	391,946.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	896,360.50	391,946.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	213,676.95	ADJUSTMENTS	0.00
COVERED CHARGES	212,091.95	CONTRACTUAL ALLOW	151,326.12
NON-COVERD CHARGES	1,585.00	TOTAL MEDICAID LIAB	60,765.83
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	60,765.83

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	48	0	52,176.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	48	0	52,176.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	48	0	52,176.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,019.00	0.00
MED/SURG SUPPLY	217.95	0.00
LABORATORY-GENERAL	58,982.00	0.00
RADIOLOGY-DIAGNOSTIC	9,558.00	0.00
CT SCAN	14,147.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,266.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,950.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,080.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	600.00	1,585.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,096.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	159,915.95	1,585.00
TOTAL ACCOMODATIONS	52,176.00	0.00
TOTAL CHARGES	212,091.95	1,585.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/22	THROUGH	07/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,645,821.32	ADJUSTMENTS	34,797.27
COVERED CHARGES	1,533,235.07	CONTRACTUAL ALLOW	1,135,644.23
NON-COVERD CHARGES	112,586.25	TOTAL MEDICAID LIAB	397,590.84
		LESS: COB	413.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	397,177.24
		ALL OTHER	348,177.51
		FEE SCHEDULE-LAB	47,055.75
		INJECTABLE DRUGS	1,943.98

TOTAL NUMBER OF CLAIMS 1,087

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,886.50	2,997.75
MED/SURG SUPPLY	674.07	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,020.00	1,475.00
CT SCAN	319,368.00	24,583.00
PHYSICAL THERAPY	5,314.00	1,838.00
EKG/ECG	19,044.00	728.00
IV THERAPY	174,001.00	15,116.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,126.00	865.00
ANESTHESIA	1,573.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	368,380.00	2,236.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	372.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	4,655.00	1,136.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,325.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,245.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	76,760.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	17,848.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,431.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	332,739.50	33,697.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	57,473.00	27,914.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,533,235.07	112,586.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,533,235.07	112,586.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,830.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,416.00	CONTRACTUAL ALLOW	18,096.68
NON-COVERD CHARGES	8,414.00	TOTAL MEDICAID LIAB	5,319.32
		LESS: COB	5,319.32
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191.00	1,385.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	864.00	0.00
CT SCAN	0.00	4,986.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	276.00	0.00
IV THERAPY	6,842.00	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	1,044.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,388.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,401.00	233.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,452.00	616.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	628.00	1,194.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	23,416.00	8,414.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,416.00	8,414.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	51,837.18	ADJUSTMENTS	0.00
COVERED CHARGES	49,882.50	CONTRACTUAL ALLOW	46,382.50
NON-COVERD CHARGES	1,954.68	TOTAL MEDICAID LIAB	3,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,500.00

TOTAL NUMBER OF CLAIMS 50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	511.50	0.00	OTHER LAB	1,096.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,684.00	343.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,453.00	190.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,408.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,614.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,116.00	1,237.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	184.68
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	49,882.50	1,954.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,882.50	1,954.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/22 THROUGH 07/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,417,014.30	ADJUSTMENTS	329,784.11
COVERED CHARGES	16,283,400.30	CONTRACTUAL ALLOW	13,699,237.05
NON-COVERD CHARGES	133,614.00	TOTAL MEDICAID LIAB	2,584,163.25
		LESS: COB	49,994.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	693.00
		REIMBURSEMENT	2,534,861.49

TOTAL NUMBER OF ADMISSIONS 329

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,072	0	1,956,398.00	0.00
ROUTINE NURSERY	43	0	53,277.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	22.00
TOTAL ROUTINE	1,115	0	2,009,675.00	22.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	180	0	958,858.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	180	0	958,858.00	0.00
TOTAL ACCOMODATIONS	1,295	0	2,968,533.00	22.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,348,980.96	0.00
MED/SURG SUPPLY	216,263.77	481.00
LABORATORY-GENERAL	3,292,604.00	0.00
RADIOLOGY-DIAGNOSTIC	188,261.00	0.00
CT SCAN	1,428,921.57	0.00
PHYSICAL THERAPY	146,853.00	0.00
EKG/ECG	209,587.00	0.00
IV THERAPY	444,263.00	0.00
OPERATING ROOM	511,871.00	0.00
LABOR/DELIVERY ROOM	105,618.00	279.00
RESPIRATORY SERVICES	2,072,882.00	0.00
ANESTHESIA	69,392.00	0.00
GI SERVICES	129,078.00	0.00
EMERGENCY ROOM	1,014,114.00	0.00
RECOVERY ROOM	154,606.00	0.00
LABORATORY PATHOLOGIC	48,788.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	116,785.00	0.00
SPEECH PATHOLOGY	34,176.00	0.00
RENAL DIALYSIS	291,512.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,249.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	93,311.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	91,649.00	53,880.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	165,022.04	36,110.00
AUDIOLOGY	11,154.00	0.00
CARDIOLOGY	480,303.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	36,261.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	152,345.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	172,492.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	232,019.14	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	3,310.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	39,532.00
IMPL DEV CHARGE PATIENTS	50,505.57	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,314,867.30	133,592.00
TOTAL ACCOMODATIONS	2,968,533.00	22.00
TOTAL CHARGES	16,283,400.30	133,614.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,125.33	ADJUSTMENTS	0.00
COVERED CHARGES	28,125.33	CONTRACTUAL ALLOW	22,825.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,300.21
		LESS: COB	5,363.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	3	0	5,472.00	0.00
ROUTINE NURSERY	1	0	1,239.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	6,711.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	6,711.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,634.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	137.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,558.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,411.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,946.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	507.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,414.33	0.00
TOTAL ACCOMODATIONS	6,711.00	0.00
TOTAL CHARGES	28,125.33	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,704,174.25	ADJUSTMENTS	97,497.27
COVERED CHARGES	12,927,474.77	CONTRACTUAL ALLOW	11,615,466.61
NON-COVERD CHARGES	1,776,699.48	TOTAL MEDICAID LIAB	1,312,008.16
		LESS: COB	1,465.16
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,310,543.00
		ALL OTHER	1,172,684.51
		FEE SCHEDULE-LAB	124,663.75
		INJECTABLE DRUGS	13,194.74

TOTAL NUMBER OF CLAIMS 2,230

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	246,747.77	915.20
MED/SURG SUPPLY	109,726.62	1,303.39
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	455,454.00	10,967.00
CT SCAN	2,200,150.00	376,239.07
PHYSICAL THERAPY	93,763.00	24,441.00
EKG/ECG	274,288.00	8,295.00
IV THERAPY	985,056.00	103,064.00
OPERATING ROOM	977,271.34	111,448.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	82,787.00	11,732.00
ANESTHESIA	118,478.00	0.00
GI SERVICES	167,848.00	91,933.00
EMERGENCY ROOM	3,576,293.04	309.00
RECOVERY ROOM	247,126.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,979.00	13,154.00
SPEECH PATHOLOGY	0.00	6,238.00
RENAL DIALYSIS	0.00	22,424.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	155.00	4,801.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	147,847.00	9,653.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,172.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	75,792.00	166,009.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	141,905.00	142,516.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	106,072.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	352,779.99	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	142,618.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,192,990.00	96,250.00
MRI SERVICES	67,905.00	113,594.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	131,404.88	112,826.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	316,256.00
IMPL DEV CHARGE PATIENTS	7,866.13	32,330.41
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,927,474.77	1,776,699.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,927,474.77	1,776,699.48

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	195,800.72	ADJUSTMENTS	0.00
COVERED CHARGES	129,226.31	CONTRACTUAL ALLOW	116,270.11
NON-COVERD CHARGES	66,574.41	TOTAL MEDICAID LIAB	12,956.20
		LESS: COB	12,956.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,255.94	499.20
MED/SURG SUPPLY	4,095.99	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,151.00	0.00
CT SCAN	6,217.00	28,649.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,106.00	1,106.00
IV THERAPY	5,950.00	3,806.00
OPERATING ROOM	13,616.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	186.00	0.00
ANESTHESIA	2,718.00	0.00
GI SERVICES	8,885.00	5,081.00
EMERGENCY ROOM	37,507.00	0.00
RECOVERY ROOM	4,921.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,556.00	1,650.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	8,801.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,159.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,333.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,828.00	6,688.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,740.88	411.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	9,883.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	129,226.31	66,574.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	129,226.31	66,574.41

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,763,033.17	ADJUSTMENTS	67.13
COVERED CHARGES	1,644,924.38	CONTRACTUAL ALLOW	1,616,796.91
NON-COVERD CHARGES	118,108.79	TOTAL MEDICAID LIAB	28,127.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	28,127.47

TOTAL NUMBER OF CLAIMS 419

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,491.37	83.20
MED/SURG SUPPLY	694.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,526.00	0.00
CT SCAN	322,798.00	29,616.02
PHYSICAL THERAPY	0.00	1,266.00
EKG/ECG	29,309.00	553.00
IV THERAPY	182,393.00	7,865.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,851.00	744.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	759,271.00	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 SERVICE	6,303.00	1,246.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	4,495.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,416.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,458.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	226,851.00	5,534.00
MRI SERVICES	8,139.00	3,887.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,424.01	3,521.57
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	59,298.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,644,924.38	118,108.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,644,924.38	118,108.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,597.68	ADJUSTMENTS	0.00
COVERED CHARGES	17,927.48	CONTRACTUAL ALLOW	17,591.83
NON-COVERD CHARGES	12,670.20	TOTAL MEDICAID LIAB	335.65
		LESS: COB	335.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191.88	83.20
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	12,146.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	3,250.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,508.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,762.00	90.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	215.60	351.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	17,927.48	12,670.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,927.48	12,670.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	272,860.39	ADJUSTMENTS	5,273.88
COVERED CHARGES	211,619.92	CONTRACTUAL ALLOW	195,798.53
NON-COVERD CHARGES	61,240.47	TOTAL MEDICAID LIAB	15,821.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	15,821.39

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,094.01	249.60
MED/SURG SUPPLY	11,872.48	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,559.00	0.00
CT SCAN	5,424.00	11,230.00
PHYSICAL THERAPY	0.00	1,961.00
EKG/ECG	2,765.00	0.00
IV THERAPY	12,916.00	0.00
OPERATING ROOM	74,026.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,065.00	186.00
ANESTHESIA	13,756.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,110.00	0.00
RECOVERY ROOM	9,842.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	1,256.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,942.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	4,495.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,513.00	6,816.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	663.03	7,811.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	4,014.40	24,293.04
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	211,619.92	61,240.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,619.92	61,240.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3202

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,690,699.15	ADJUSTMENTS	3,124,276.83
COVERED CHARGES	78,285,441.07	CONTRACTUAL ALLOW	65,959,408.61
NON-COVERD CHARGES	405,258.08	TOTAL MEDICAID LIAB	12,326,032.46
		LESS: COB	141,683.30
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	4,032.00
		REIMBURSEMENT	12,188,381.16

TOTAL NUMBER OF ADMISSIONS 1,093

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,470	0	8,023,391.00	0.00
ROUTINE NURSERY	394	0	899,400.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	56.00
TOTAL ROUTINE	4,864	0	8,922,791.00	56.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,381	0	7,329,477.00	0.00
NICU	40	0	250,840.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,421	0	7,580,317.00	0.00
TOTAL ACCOMODATIONS	6,285	0	16,503,108.00	56.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,889,882.80	0.00
MED/SURG SUPPLY	1,257,005.84	742.08
LABORATORY-GENERAL	14,454,671.00	0.00
RADIOLOGY-DIAGNOSTIC	917,745.00	0.00
CT SCAN	4,682,515.53	49,164.00
PHYSICAL THERAPY	300,701.00	0.00
EKG/ECG	398,160.00	0.00
IV THERAPY	1,250,734.00	0.00
OPERATING ROOM	3,866,222.00	0.00
LABOR/DELIVERY ROOM	365,352.00	558.00
RESPIRATORY SERVICES	9,696,277.00	0.00
ANESTHESIA	486,184.00	0.00
GI SERVICES	521,293.00	0.00
EMERGENCY ROOM	3,695,936.00	0.00
RECOVERY ROOM	698,834.00	0.00
LABORATORY PATHOLOGIC	360,661.00	0.00
RADIOLOGY THERAPEUTIC	98,814.00	0.00
OCCUPATIONAL THERAPY	154,430.00	0.00
SPEECH PATHOLOGY	162,738.00	0.00
RENAL DIALYSIS	1,999,934.00	44,848.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25,363.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	435,559.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	832,634.00	239,766.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	175,500.04	40,475.00
AUDIOLOGY	58,337.00	0.00
CARDIOLOGY	3,436,931.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	107,637.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	329,654.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	468,893.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	21,824.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	729,981.30	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	29,649.00
IMPL DEV CHARGE PATIENTS	901,929.56	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	61,782,333.07	405,202.08
TOTAL ACCOMODATIONS	16,503,108.00	56.00
TOTAL CHARGES	78,285,441.07	405,258.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,852,713.94	ADJUSTMENTS	0.00
COVERED CHARGES	2,846,507.94	CONTRACTUAL ALLOW	2,521,391.49
NON-COVERD CHARGES	6,206.00	TOTAL MEDICAID LIAB	325,116.45
		LESS: COB	325,746.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	630.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	200	0	415,776.00	0.00
ROUTINE NURSERY	59	0	208,208.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	259	0	623,984.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	26,135.00	0.00
NICU	28	0	175,588.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	33	0	201,723.00	0.00
TOTAL ACCOMODATIONS	292	0	825,707.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,229.90	0.00
MED/SURG SUPPLY	120,092.34	0.00
LABORATORY-GENERAL	424,494.71	0.00
RADIOLOGY-DIAGNOSTIC	51,797.50	0.00
CT SCAN	29,050.00	0.00
PHYSICAL THERAPY	2,130.00	0.00
EKG/ECG	3,871.00	0.00
IV THERAPY	15,233.00	0.00
OPERATING ROOM	113,242.00	0.00
LABOR/DELIVERY ROOM	111,796.00	279.00
RESPIRATORY SERVICES	526,962.00	0.00
ANESTHESIA	21,662.00	0.00
GI SERVICES	5,482.00	0.00
EMERGENCY ROOM	39,169.00	0.00
RECOVERY ROOM	57,450.00	0.00
LABORATORY PATHOLOGIC	18,571.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,178.00	0.00
SPEECH PATHOLOGY	2,508.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,433.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	66,026.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,240.00	5,927.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	4,056.00	0.00
CARDIOLOGY	106,042.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,887.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,659.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	5,623.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	528.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	2,629.06	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,562.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	28,196.93	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,020,800.94	6,206.00
TOTAL ACCOMODATIONS	825,707.00	0.00
TOTAL CHARGES	2,846,507.94	6,206.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,285,041.78	ADJUSTMENTS	415,187.90
COVERED CHARGES	23,270,811.70	CONTRACTUAL ALLOW	20,935,275.30
NON-COVERD CHARGES	5,014,230.08	TOTAL MEDICAID LIAB	2,335,536.40
		LESS: COB	6,857.65
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,328,678.75
		ALL OTHER	2,017,336.31
		FEE SCHEDULE-LAB	153,838.36
		INJECTABLE DRUGS	157,504.08

TOTAL NUMBER OF CLAIMS 3,741

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,064.95	499.20
MED/SURG SUPPLY	318,124.66	104,050.52
LABORATORY-GENERAL	0.00	360.00
RADIOLOGY-DIAGNOSTIC	700,108.00	17,408.00
CT SCAN	2,843,538.00	593,224.07
PHYSICAL THERAPY	48,850.00	13,404.00
EKG/ECG	280,371.00	3,871.00
IV THERAPY	1,611,896.00	183,910.00
OPERATING ROOM	1,629,258.82	443,878.18
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	332,268.00	59,319.00
ANESTHESIA	250,889.00	2,948.00
GI SERVICES	186,832.00	73,934.00
EMERGENCY ROOM	4,976,483.01	4,625.00
RECOVERY ROOM	360,067.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,384,259.00	279,250.00
OCCUPATIONAL THERAPY	5,914.00	6,595.00
SPEECH PATHOLOGY	2,244.00	8,592.00
RENAL DIALYSIS	0.00	559,319.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	310.00	2,945.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	572,327.00	57,185.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	54,738.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	67,718.00	100,317.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	469,447.00	688,334.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,413.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	629,930.85	17,061.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	370,639.00	3,670.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,155,750.00	143,924.00
MRI SERVICES	123,156.00	192,309.01
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,637.83
INJECTABLE DRUGS	530,474.45	467,572.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	148,245.00
IMPL DEV CHARGE PATIENTS	91,740.96	832,842.47
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	23,270,811.70	5,014,230.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,270,811.70	5,014,230.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	504,949.06	ADJUSTMENTS	0.00
COVERED CHARGES	340,385.13	CONTRACTUAL ALLOW	308,749.51
NON-COVERD CHARGES	164,563.93	TOTAL MEDICAID LIAB	31,635.62
		LESS: COB	31,635.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,436.56	688.81
MED/SURG SUPPLY	4,718.27	1,000.92
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,976.00	2,584.00
CT SCAN	14,045.00	27,869.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,977.00	0.00
IV THERAPY	28,810.00	2,228.00
OPERATING ROOM	54,471.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,912.00	0.00
ANESTHESIA	6,378.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	96,983.00	0.00
RECOVERY ROOM	13,271.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	5,606.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,807.00	4,374.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,687.00	104.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,384.00	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/OBSERV. RM	3,672.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,694.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	55,384.00	3,887.00
MRI SERVICES	0.00	5,788.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,779.30	99,719.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	9,883.00
IMPL DEV CHARGE PATIENTS	0.00	832.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	340,385.13	164,563.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	340,385.13	164,563.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,316,991.56	ADJUSTMENTS	402.78
COVERED CHARGES	2,172,793.89	CONTRACTUAL ALLOW	2,138,624.72
NON-COVERD CHARGES	144,197.67	TOTAL MEDICAID LIAB	34,169.17
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	34,169.17

TOTAL NUMBER OF CLAIMS 509

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,883.38	83.20
MED/SURG SUPPLY	622.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,337.00	649.00
CT SCAN	447,959.00	49,740.00
PHYSICAL THERAPY	0.00	589.00
EKG/ECG	34,839.00	0.00
IV THERAPY	185,890.00	35,982.00
OPERATING ROOM	4,738.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,208.00	658.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	876,573.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	376.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	17,812.00	8,280.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	15,396.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,827.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	24,596.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	392,428.00	10,123.00
MRI SERVICES	11,700.00	6,374.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,985.23	11,577.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	19,766.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,172,793.89	144,197.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,172,793.89	144,197.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,087.37	ADJUSTMENTS	0.00
COVERED CHARGES	33,632.10	CONTRACTUAL ALLOW	32,893.67
NON-COVERD CHARGES	11,455.27	TOTAL MEDICAID LIAB	738.43
		LESS: COB	738.43
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	337.10	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,884.00	0.00
CT SCAN	0.00	9,595.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	3,815.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,348.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,394.00	1,412.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,654.00	315.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	200.00	133.27
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	33,632.10	11,455.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,632.10	11,455.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	616,793.01	ADJUSTMENTS	5,697.47
COVERED CHARGES	563,509.05	CONTRACTUAL ALLOW	523,626.76
NON-COVERD CHARGES	53,283.96	TOTAL MEDICAID LIAB	39,882.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	39,882.29

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,103.57	0.00
MED/SURG SUPPLY	19,954.10	3,102.44
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,254.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,917.00	459.00
OPERATING ROOM	189,535.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,292.00	758.00
ANESTHESIA	29,471.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,943.00	0.00
RECOVERY ROOM	25,050.00	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	55,795.00	2,744.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,069.00	983.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	214,716.73	14,592.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	6,408.65	30,645.24
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	563,509.05	53,283.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	563,509.05	53,283.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,410,912.21	ADJUSTMENTS	1,390,826.99
COVERED CHARGES	59,294,573.96	CONTRACTUAL ALLOW	52,990,935.89
NON-COVERD CHARGES	116,338.25	TOTAL MEDICAID LIAB	6,303,638.07
		LESS: COB	175,248.76
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,134.00
		REIMBURSEMENT	6,129,523.31

TOTAL NUMBER OF ADMISSIONS 642

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,342	0	10,106,472.00	0.00
ROUTINE NURSERY	307	0	934,117.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	18.00
TOTAL ROUTINE	3,649	0	11,040,589.00	18.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,029	0	4,281,895.00	0.00
NICU	10	0	57,960.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,039	0	4,339,855.00	0.00
TOTAL ACCOMODATIONS	4,688	0	15,380,444.00	18.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,165,123.42	0.00
MED/SURG SUPPLY	1,306,216.42	0.00
LABORATORY-GENERAL	12,756,330.38	0.00
RADIOLOGY-DIAGNOSTIC	860,928.41	0.00
CT SCAN	4,628,111.83	21,793.99
PHYSICAL THERAPY	733,652.98	0.00
EKG/ECG	769,850.50	0.00
IV THERAPY	575,598.59	0.00
OPERATING ROOM	2,035,106.22	0.00
LABOR/DELIVERY ROOM	104,945.24	0.00
RESPIRATORY SERVICES	4,934,047.15	0.00
ANESTHESIA	524,326.82	0.00
GI SERVICES	265,193.66	0.00
EMERGENCY ROOM	1,843,932.23	0.00
RECOVERY ROOM	553,208.00	0.00
LABORATORY PATHOLOGIC	194,466.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	466,159.91	0.00
SPEECH PATHOLOGY	349,899.95	0.00
RENAL DIALYSIS	670,469.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,844.22	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	229,400.26	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	149,652.79	58,423.64
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	627,453.31	34,528.96
AUDIOLOGY	262.50	0.00
CARDIOLOGY	2,172,792.59	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	74,594.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	397,033.61	1,239.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	276,472.87	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	334.66
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	670,056.45	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	562,567.81	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	6,431.83	0.00

TOTAL ANCILLARY	43,914,129.96	116,320.25
TOTAL ACCOMODATIONS	15,380,444.00	18.00
TOTAL CHARGES	59,294,573.96	116,338.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2323255000050	05/17/23 - 05/22/23	10/16/23	6,431.83	0.00	0.00	0.00	0.00
TOTAL				6,431.83	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	276,224.39	ADJUSTMENTS	0.00
COVERED CHARGES	276,224.39	CONTRACTUAL ALLOW	201,445.61
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	74,778.78
		LESS: COB	74,841.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		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	11	0	23,042.00	0.00
ROUTINE NURSERY	20	0	62,748.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	85,790.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	10,860.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	10,860.00	0.00
TOTAL ACCOMODATIONS	34	0	96,650.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,505.61	0.00	OTHER LAB	582.00	0.00
MED/SURG SUPPLY	1,399.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,346.09	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	986.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,936.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,471.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,155.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,356.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,242.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,438.82	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,244.11	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,596.14	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,293.45	0.00			

TOTAL ANCILLARY	179,574.39	0.00
TOTAL ACCOMODATIONS	96,650.00	0.00
TOTAL CHARGES	276,224.39	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,104,878.97	ADJUSTMENTS	104,854.54
COVERED CHARGES	13,965,524.58	CONTRACTUAL ALLOW	12,869,659.30
NON-COVERD CHARGES	2,139,354.39	TOTAL MEDICAID LIAB	1,095,865.28
		LESS: COB	3,805.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,092,059.34
		ALL OTHER	985,690.25
		FEE SCHEDULE-LAB	78,411.04
		INJECTABLE DRUGS	27,958.05

TOTAL NUMBER OF CLAIMS 2,023

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,426.68	665.60
MED/SURG SUPPLY	179,280.94	29,424.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	609,154.52	8,297.66
CT SCAN	2,613,249.45	324,948.19
PHYSICAL THERAPY	159,818.06	29,637.98
EKG/ECG	315,157.50	14,681.25
IV THERAPY	612,289.19	105,993.10
OPERATING ROOM	401,972.18	133,828.77
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	42,142.53	13,437.07
ANESTHESIA	149,966.13	0.00
GI SERVICES	30,259.39	7,882.00
EMERGENCY ROOM	3,184,048.55	6,492.05
RECOVERY ROOM	300,324.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,323.16	17,220.51
SPEECH PATHOLOGY	801.15	16,563.35
RENAL DIALYSIS	0.00	14,625.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	695.74	5,218.05
PSYCHIATRIC SERVICES	26,797.76	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	282,778.16	22,441.74
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	485.56	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	343,322.25	359,012.04
AUDIOLOGY	0.00	0.00
CARDIOLOGY	276,693.36	533,004.05
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	737,150.74	95,557.22

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	165,723.90	6,588.86
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	412.78
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,081,472.27	115,162.19
MRI SERVICES	96,041.72	68,746.42
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	200,319.73	55,472.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	18,829.96	154,042.35
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	13,965,524.58	2,139,354.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,965,524.58	2,139,354.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	411,309.66	ADJUSTMENTS	0.00
COVERED CHARGES	367,260.82	CONTRACTUAL ALLOW	336,507.88
NON-COVERD CHARGES	44,048.84	TOTAL MEDICAID LIAB	30,752.94
		LESS: COB	30,752.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,860.64	665.60
MED/SURG SUPPLY	81,559.03	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,178.33	0.00
CT SCAN	12,306.55	5,309.47
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,936.25	0.00
IV THERAPY	3,176.88	422.25
OPERATING ROOM	17,302.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	500.84	0.00
ANESTHESIA	3,500.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	56,830.07	0.00
RECOVERY ROOM	10,600.00	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	75,520.96	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,958.12	4,278.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,371.06	1,633.52
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,430.97	4,281.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,591.58	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	794.85	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	54,495.77	3,439.32
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,346.92	24,019.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	367,260.82	44,048.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	367,260.82	44,048.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,898,847.40	ADJUSTMENTS	67.13
COVERED CHARGES	1,827,677.07	CONTRACTUAL ALLOW	1,804,785.74
NON-COVERD CHARGES	71,170.33	TOTAL MEDICAID LIAB	22,891.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	22,891.33

TOTAL NUMBER OF CLAIMS 341

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,690.66	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101,359.03	812.75
CT SCAN	461,567.07	35,031.02
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	44,043.75	0.00
IV THERAPY	99,444.90	17,031.62
OPERATING ROOM	0.00	1,368.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	261.66	523.53
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	728,208.80	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 SERVICE	8,534.32	4,696.35
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/OBSERV. RM	3,902.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,884.13	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	358,881.91	9,034.81
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,898.49	2,672.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,827,677.07	71,170.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,827,677.07	71,170.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	65,622.55	ADJUSTMENTS	0.00
COVERED CHARGES	53,847.37	CONTRACTUAL ALLOW	53,310.33
NON-COVERD CHARGES	11,775.18	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	229.31	83.20
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,196.28	812.75
CT SCAN	5,309.47	10,618.95
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,957.50	0.00
IV THERAPY	2,848.75	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	22,922.59	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,367.87	244.68
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.60	15.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	53,847.37	11,775.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,847.37	11,775.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	523,200.76	ADJUSTMENTS	10,868.43
COVERED CHARGES	398,534.25	CONTRACTUAL ALLOW	365,928.85
NON-COVERD CHARGES	124,666.51	TOTAL MEDICAID LIAB	32,605.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	32,605.40

TOTAL NUMBER OF CLAIMS 6

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,662.73	0.00
MED/SURG SUPPLY	6,696.67	13,534.65
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,860.23	0.00
CT SCAN	28,671.19	0.00
PHYSICAL THERAPY	0.00	6,355.89
EKG/ECG	4,893.75	0.00
IV THERAPY	2,251.33	1,001.21
OPERATING ROOM	104,490.43	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	34,358.01	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,726.15	0.00
RECOVERY ROOM	30,600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	830.79
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,877.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	91,436.09	45,126.79
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	7,024.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,294.43	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,171.62	0.00
MRI SERVICES	15,945.39	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,216.47	4,059.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	12,357.80	53,757.70
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	398,534.25	124,666.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	398,534.25	124,666.51

EASTSIDE MEDICAL CENTER LLC
1700 MEDICAL WAY
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,507,026.88	ADJUSTMENTS	4,168.59
COVERED CHARGES	4,504,413.88	CONTRACTUAL ALLOW	3,405,241.48
NON-COVERD CHARGES	2,613.00	TOTAL MEDICAID LIAB	1,099,172.40
		LESS: COB	3,329.94
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	8,000.00
		REIMBURSEMENT	1,103,842.46

TOTAL NUMBER OF ADMISSIONS 265

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,004	0	2,843,404.00	0.00
ROUTINE NURSERY	31	0	26,536.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,035	0	2,869,940.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,035	0	2,869,940.00	0.00

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,019,054.88	0.00
MED/SURG SUPPLY	68,017.00	0.00
LABORATORY-GENERAL	335,773.00	0.00
RADIOLOGY-DIAGNOSTIC	38,758.00	0.00
CT SCAN	36,165.00	0.00
PHYSICAL THERAPY	25,399.00	0.00
EKG/ECG	5,216.00	0.00
IV THERAPY	13,559.00	0.00
OPERATING ROOM	30,843.00	0.00
LABOR/DELIVERY ROOM	1,672.00	1,425.00
RESPIRATORY SERVICES	7,559.00	0.00
ANESTHESIA	3,724.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,905.00	0.00
RECOVERY ROOM	8,165.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,669.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,572.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,043.00	1,188.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,710.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	664.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,157.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,849.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,634,473.88	2,613.00
TOTAL ACCOMODATIONS	2,869,940.00	0.00
TOTAL CHARGES	4,504,413.88	2,613.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,240,574.52	ADJUSTMENTS	229.88
COVERED CHARGES	1,012,717.52	CONTRACTUAL ALLOW	841,958.45
NON-COVERD CHARGES	227,857.00	TOTAL MEDICAID LIAB	170,759.07
		LESS: COB	45.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	170,713.88
		ALL OTHER	141,369.95
		FEE SCHEDULE-LAB	29,120.45
		INJECTABLE DRUGS	223.48

TOTAL NUMBER OF CLAIMS 736

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,878.20	40,884.00
MED/SURG SUPPLY	114,628.00	375.00
LABORATORY-GENERAL	0.00	1,728.00
RADIOLOGY-DIAGNOSTIC	70,297.00	15,116.00
CT SCAN	54,963.00	33,356.00
PHYSICAL THERAPY	44,399.00	8,118.00
EKG/ECG	9,853.00	0.00
IV THERAPY	50,687.00	3,891.00
OPERATING ROOM	51,657.00	81,681.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,183.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	88,987.00	0.00
RECOVERY ROOM	39,192.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,254.00	0.00
SPEECH PATHOLOGY	0.00	256.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	780.00	660.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	41,533.31	1,868.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,115.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,710.00	855.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	8,054.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,289.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	384,574.00	34,212.00
MRI SERVICES	8,314.00	3,203.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,370.01	1,654.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,012,717.52	227,857.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,012,717.52	227,857.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,310.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,812.00	CONTRACTUAL ALLOW	15,863.05
NON-COVERD CHARGES	1,498.00	TOTAL MEDICAID LIAB	3,948.95
		LESS: COB	3,948.95
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122.00	649.00	OTHER LAB	2,422.00	0.00
MED/SURG SUPPLY	2,583.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,674.00	462.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	972.00	387.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,919.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,568.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,284.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,633.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	635.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,812.00	1,498.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,812.00	1,498.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,393.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,477.00	CONTRACTUAL ALLOW	9,537.16
NON-COVERD CHARGES	2,916.00	TOTAL MEDICAID LIAB	939.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	939.84

TOTAL NUMBER OF CLAIMS 12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230.00	126.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	422.00	0.00
CT SCAN	2,316.00	2,190.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	198.00	0.00
IV THERAPY	706.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,309.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,296.00	600.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	10,477.00	2,916.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,477.00	2,916.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,394.00	ADJUSTMENTS	0.00
COVERED CHARGES	22,787.00	CONTRACTUAL ALLOW	17,846.79
NON-COVERD CHARGES	7,607.00	TOTAL MEDICAID LIAB	4,940.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,940.21

TOTAL NUMBER OF CLAIMS 1

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,445.00	0.00
MED/SURG SUPPLY	19,709.00	56.00
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	7,551.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,633.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	22,787.00	7,607.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,787.00	7,607.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,630,271.02	ADJUSTMENTS	62,573.88
COVERED CHARGES	5,614,070.44	CONTRACTUAL ALLOW	4,608,865.26
NON-COVERD CHARGES	16,200.58	TOTAL MEDICAID LIAB	1,005,205.18
		LESS: COB	9,473.90
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	995,731.28

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	357	0	712,926.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	3.00
TOTAL ROUTINE	357	0	712,926.00	3.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	8	0	30,235.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	30,235.00	0.00
TOTAL ACCOMODATIONS	365	0	743,161.00	3.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,172.67	0.00
MED/SURG SUPPLY	100,659.42	0.00
LABORATORY-GENERAL	1,370,783.85	0.00
RADIOLOGY-DIAGNOSTIC	159,664.24	0.00
CT SCAN	612,403.09	0.00
PHYSICAL THERAPY	46,955.12	0.00
EKG/ECG	65,973.60	0.00
IV THERAPY	119,322.17	0.00
OPERATING ROOM	534,876.56	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	129,827.48	0.00
ANESTHESIA	155,147.25	0.00
GI SERVICES	12,064.00	0.00
EMERGENCY ROOM	255,037.10	0.00
RECOVERY ROOM	96,213.00	0.00
LABORATORY PATHOLOGIC	14,607.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	42,833.70	0.00
SPEECH PATHOLOGY	564.90	0.00
RENAL DIALYSIS	28,238.70	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	59,172.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,858.07	14,891.38
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,042.35	1,306.20
AUDIOLOGY	0.00	0.00
CARDIOLOGY	205,129.72	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	19,062.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	12,140.99	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	190,076.32	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	262,082.14	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	4,870,909.44	16,197.58
TOTAL ACCOMODATIONS	743,161.00	3.00
TOTAL CHARGES	5,614,070.44	16,200.58

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,979,204.05	ADJUSTMENTS	62,431.17
COVERED CHARGES	11,485,075.98	CONTRACTUAL ALLOW	10,741,219.00
NON-COVERD CHARGES	1,494,128.07	TOTAL MEDICAID LIAB	743,856.98
		LESS: COB	723.20
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	743,133.78
		ALL OTHER	650,329.48
		FEE SCHEDULE-LAB	87,106.30
		INJECTABLE DRUGS	5,698.00

TOTAL NUMBER OF CLAIMS 1,749

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,595.91	665.60
MED/SURG SUPPLY	178,405.32	1,820.93
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,054,148.43	8,834.70
CT SCAN	2,085,459.60	269,939.28
PHYSICAL THERAPY	0.00	16,263.71
EKG/ECG	206,756.55	5,890.50
IV THERAPY	576,729.12	47,091.94
OPERATING ROOM	1,132,307.23	110,872.16
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	48,332.48	16,957.50
ANESTHESIA	376,200.00	0.00
GI SERVICES	40,397.04	49,715.00
EMERGENCY ROOM	2,529,942.30	1,464.00
RECOVERY ROOM	304,581.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	17,109.75
SPEECH PATHOLOGY	0.00	564.90
RENAL DIALYSIS	0.00	3,322.20
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	178.50	1,963.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	103,282.20	7,566.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,912.97	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,641.65	99.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,780.60	12,780.60
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	69,480.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	41,797.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,371,976.92	222,520.75
MRI SERVICES	49,078.05	55,972.35
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	72,985.22	196,907.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	64,106.39	445,805.75
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	11,485,075.98	1,494,128.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,485,075.98	1,494,128.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	117,381.63	ADJUSTMENTS	0.00
COVERED CHARGES	87,254.25	CONTRACTUAL ALLOW	81,517.85
NON-COVERD CHARGES	30,127.38	TOTAL MEDICAID LIAB	5,736.40
		LESS: COB	5,736.40
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,684.08	83.20
MED/SURG SUPPLY	7,351.20	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,741.80	0.00
CT SCAN	6,949.95	17,966.55
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,178.10	0.00
IV THERAPY	3,539.96	1,074.01
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,491.33	58.80
ANESTHESIA	0.00	0.00
GI SERVICES	6,952.27	7,882.00
EMERGENCY ROOM	31,729.48	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,900.24	2,619.75
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	735.84	443.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	87,254.25	30,127.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,254.25	30,127.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,540,075.29	ADJUSTMENTS	67.13
COVERED CHARGES	1,508,132.33	CONTRACTUAL ALLOW	1,480,609.02
NON-COVERD CHARGES	31,942.96	TOTAL MEDICAID LIAB	27,523.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	27,523.31

TOTAL NUMBER OF CLAIMS 411

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,104.37	0.00
MED/SURG SUPPLY	66.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	195,418.65	1,192.80
CT SCAN	374,958.15	10,540.95
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	20,616.75	2,356.20
IV THERAPY	69,075.29	3,473.45
OPERATING ROOM	0.00	2,186.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,054.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	547,370.96	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 SERVICE	7,206.15	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	3,590.38	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	275,066.79	7,498.80
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,604.64	4,693.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,508,132.33	31,942.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,508,132.33	31,942.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,321.06	ADJUSTMENTS	0.00
COVERED CHARGES	49,980.47	CONTRACTUAL ALLOW	49,443.43
NON-COVERD CHARGES	19,340.59	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.96	249.60
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,324.00	0.00
CT SCAN	18,419.10	17,460.45
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	3,939.61	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,123.30	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 SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,025.70	1,432.20
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	98.80	198.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	49,980.47	19,340.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,980.47	19,340.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,411.24	ADJUSTMENTS	0.00
COVERED CHARGES	81,803.75	CONTRACTUAL ALLOW	76,175.39
NON-COVERD CHARGES	607.49	TOTAL MEDICAID LIAB	5,628.36
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,628.36

TOTAL NUMBER OF CLAIMS 1

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,635.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,196.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,302.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,900.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,031.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	163.19	607.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	574.91	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	81,803.75	607.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	81,803.75	607.49

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON NORTHSIDE HOSPITAL, LLC
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,249,973.77	ADJUSTMENTS	208,402.74
COVERED CHARGES	7,223,962.77	CONTRACTUAL ALLOW	5,892,055.52
NON-COVERD CHARGES	26,011.00	TOTAL MEDICAID LIAB	1,331,907.25
		LESS: COB	10,644.60
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,321,262.65

TOTAL NUMBER OF ADMISSIONS 148

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	607	0	747,529.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	4.00
TOTAL ROUTINE	607	0	747,529.00	4.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	111	0	304,285.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	111	0	304,285.00	0.00
TOTAL ACCOMODATIONS	718	0	1,051,814.00	4.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,205,344.73	0.00
MED/SURG SUPPLY	215,637.26	0.00
LABORATORY-GENERAL	1,687,587.00	0.00
RADIOLOGY-DIAGNOSTIC	79,029.00	0.00
CT SCAN	405,638.00	0.00
PHYSICAL THERAPY	32,708.00	0.00
EKG/ECG	41,614.00	0.00
IV THERAPY	279,511.00	0.00
OPERATING ROOM	467,919.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	423,679.00	0.00
ANESTHESIA	56,615.00	0.00
GI SERVICES	39,060.00	0.00
EMERGENCY ROOM	424,142.00	0.00
RECOVERY ROOM	89,289.00	0.00
LABORATORY PATHOLOGIC	36,781.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	41,319.00	0.00
SPEECH PATHOLOGY	5,276.00	0.00
RENAL DIALYSIS	30,471.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	306.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	12,221.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	52,204.00	25,542.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,319.00	465.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	62,082.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,143.12	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	17,214.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	43,952.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	409,087.66	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	6,172,148.77	26,007.00
TOTAL ACCOMODATIONS	1,051,814.00	4.00
TOTAL CHARGES	7,223,962.77	26,011.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,299,623.46	ADJUSTMENTS	46,366.14
COVERED CHARGES	5,315,333.60	CONTRACTUAL ALLOW	4,640,486.17
NON-COVERD CHARGES	984,289.86	TOTAL MEDICAID LIAB	674,847.43
		LESS: COB	2,661.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	672,185.62
		ALL OTHER	617,489.14
		FEE SCHEDULE-LAB	41,299.60
		INJECTABLE DRUGS	13,396.88

TOTAL NUMBER OF CLAIMS 1,146

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,621.17	416.00
MED/SURG SUPPLY	227,014.58	5,151.04
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	155,978.00	3,039.00
CT SCAN	463,278.00	114,533.00
PHYSICAL THERAPY	28,618.00	14,809.00
EKG/ECG	49,815.00	3,159.00
IV THERAPY	513,622.00	73,243.00
OPERATING ROOM	568,657.50	44,862.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,058.00	1,438.00
ANESTHESIA	78,884.00	0.00
GI SERVICES	101,001.00	68,355.00
EMERGENCY ROOM	1,555,356.02	195.00
RECOVERY ROOM	180,055.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,494.00
SPEECH PATHOLOGY	0.00	804.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,376.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	32,238.00	0.00
OTHER IMAGING SERVICE	19,804.00	508.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,494.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,899.00	3,840.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	240,019.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	13,488.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	19,826.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	817,197.00	64,340.00
MRI SERVICES	3,403.00	6,105.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	111,630.28	39,694.51
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	15,376.80	534,927.81
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,315,333.60	984,289.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,315,333.60	984,289.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,499.63	ADJUSTMENTS	0.00
COVERED CHARGES	99,983.95	CONTRACTUAL ALLOW	88,248.76
NON-COVERD CHARGES	20,515.68	TOTAL MEDICAID LIAB	11,735.19
		LESS: COB	11,735.19
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	879.82	791.53
MED/SURG SUPPLY	6,545.07	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,431.00	498.00
CT SCAN	0.00	7,910.00
PHYSICAL THERAPY	157.00	0.00
EKG/ECG	972.00	0.00
IV THERAPY	18,296.00	459.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	407.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	6,510.00	6,510.00
EMERGENCY ROOM	34,101.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,204.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	22,185.00	2,988.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,296.05	1,359.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	99,983.95	20,515.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,983.95	20,515.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	193,127.81	ADJUSTMENTS	134.26
COVERED CHARGES	182,980.07	CONTRACTUAL ALLOW	177,609.67
NON-COVERD CHARGES	10,147.74	TOTAL MEDICAID LIAB	5,370.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,370.40

TOTAL NUMBER OF CLAIMS 80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,595.79	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,809.00	0.00
CT SCAN	6,997.00	5,049.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,215.00	0.00
IV THERAPY	19,081.00	2,256.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	501.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	108,397.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,016.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	464.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33,028.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	876.28	2,842.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	182,980.07	10,147.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	182,980.07	10,147.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	25,230.33	ADJUSTMENTS	0.00
COVERED CHARGES	24,711.64	CONTRACTUAL ALLOW	24,308.86
NON-COVERD CHARGES	518.69	TOTAL MEDICAID LIAB	402.78
		LESS: COB	402.78
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234.44	83.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	558.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,715.00	362.00
EKG/ECG	243.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,754.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,098.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	109.20	73.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,711.64	518.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,711.64	518.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	260,593.40	ADJUSTMENTS	0.00
COVERED CHARGES	244,369.94	CONTRACTUAL ALLOW	218,938.44
NON-COVERD CHARGES	16,223.46	TOTAL MEDICAID LIAB	25,431.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,431.50

TOTAL NUMBER OF CLAIMS 5

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,302.77	0.00
MED/SURG SUPPLY	44,796.74	57.38
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	700.00
EKG/ECG	243.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	60,968.10	11,428.90
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	8,062.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	18,296.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	32,238.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,229.57	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,696.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,635.06	2,377.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	63,902.70	1,659.34
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	244,369.94	16,223.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	244,369.94	16,223.46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL, INC.
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ENCOMPASS HLTH WALTON REHAB HOSP,LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,114,727.06	ADJUSTMENTS	46,115.84
COVERED CHARGES	7,083,144.06	CONTRACTUAL ALLOW	5,905,447.96
NON-COVERD CHARGES	31,583.00	TOTAL MEDICAID LIAB	1,177,696.10
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,177,696.10

TOTAL NUMBER OF ADMISSIONS 200

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	642	0	1,150,968.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	642	0	1,150,968.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	642	0	1,150,968.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	835,082.50	0.00
MED/SURG SUPPLY	86,278.50	0.00
LABORATORY-GENERAL	930,845.00	0.00
RADIOLOGY-DIAGNOSTIC	195,316.50	0.00
CT SCAN	21,961.50	0.00
PHYSICAL THERAPY	57,553.50	0.00
EKG/ECG	10,455.00	0.00
IV THERAPY	116,222.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,803,907.56	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	677,200.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,518.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	217.00	23,270.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	42,974.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	95,099.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,085.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	15,744.00	1,600.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	6,576.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	881.50
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	139.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	5,831.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,932,176.06	31,583.00
TOTAL ACCOMODATIONS	1,150,968.00	0.00
TOTAL CHARGES	7,083,144.06	31,583.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	85,648.00	ADJUSTMENTS	0.00
COVERED CHARGES	85,648.00	CONTRACTUAL ALLOW	71,917.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	13,730.86
		LESS: COB	13,730.86
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7	0	12,446.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	12,446.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	12,446.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,850.50	0.00	OTHER LAB	6,055.00	0.00
MED/SURG SUPPLY	555.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,254.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,435.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,053.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,532.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	3,466.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,202.00	0.00
TOTAL ACCOMODATIONS	12,446.00	0.00
TOTAL CHARGES	85,648.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,420,398.62	ADJUSTMENTS	170,069.22
COVERED CHARGES	17,522,534.32	CONTRACTUAL ALLOW	14,399,951.70
NON-COVERD CHARGES	897,864.30	TOTAL MEDICAID LIAB	3,122,582.62
		LESS: COB	5,916.63
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,116,665.99
		ALL OTHER	2,762,927.47
		FEE SCHEDULE-LAB	134,889.53
		INJECTABLE DRUGS	218,848.99

TOTAL NUMBER OF CLAIMS 6,806

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,010.25	379.75
MED/SURG SUPPLY	326,963.35	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	587,969.50	9,088.00
CT SCAN	206,966.00	5,437.00
PHYSICAL THERAPY	0.00	787.50
EKG/ECG	50,790.00	687.00
IV THERAPY	198,071.00	27,092.50
OPERATING ROOM	80,380.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	522,069.02	208,678.50
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,488,179.50	18,144.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,902.50	2,709.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,616.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,180,144.00	25,480.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	192,882.50	26,863.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	268,969.00	10,913.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	923.00
CARDIOLOGY	18,806.50	30,393.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	63,311.50	15,877.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	186,167.50	3,384.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,944,811.50	407,315.25
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	3,460.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	943,140.70	95,225.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	2,411.00

TOTAL ANCILLARY	17,522,534.32	897,864.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,522,534.32	897,864.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
970	2023039080729	01/13/23 - 01/13/23	02/13/23	0.00	1,205.50	0.00	0.00	0.00
970	2223145001059	01/24/23 - 01/24/23	05/29/23	0.00	1,205.50	0.00	0.00	0.00
TOTAL				0.00	2,411.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	156,933.00	ADJUSTMENTS	0.00
COVERED CHARGES	147,410.25	CONTRACTUAL ALLOW	120,080.98
NON-COVERD CHARGES	9,522.75	TOTAL MEDICAID LIAB	27,329.27
		LESS: COB	27,329.27
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,585.50	0.00
MED/SURG SUPPLY	2,362.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,110.00	0.00
CT SCAN	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	5,257.50	4,204.50
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	78,417.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	218.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	38,016.50	319.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	35.50
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,330.00	1,481.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	1,485.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	331.25	1,779.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	147,410.25	9,522.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,410.25	9,522.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,182,475.00	ADJUSTMENTS	335.65
COVERED CHARGES	1,160,589.00	CONTRACTUAL ALLOW	1,130,581.89
NON-COVERD CHARGES	21,886.00	TOTAL MEDICAID LIAB	30,007.11
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	30,007.11

TOTAL NUMBER OF CLAIMS 447

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,293.75	0.00
MED/SURG SUPPLY	4,223.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,508.00	0.00
CT SCAN	9,938.00	4,969.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,845.00	0.00
IV THERAPY	3,213.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,371.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	945,964.00	1,116.50
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	1,863.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	6,143.00	2,054.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	960.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,997.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	124,470.25	13,583.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,799.00	163.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,160,589.00	21,886.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,160,589.00	21,886.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,482.50	ADJUSTMENTS	0.00
COVERED CHARGES	48,229.50	CONTRACTUAL ALLOW	47,088.29
NON-COVERD CHARGES	253.00	TOTAL MEDICAID LIAB	1,141.21
		LESS: COB	1,141.21
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,265.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,386.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,202.50	253.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,577.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,729.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	48,229.50	253.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,229.50	253.00

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,949.00	ADJUSTMENTS	0.00
COVERED CHARGES	87,949.00	CONTRACTUAL ALLOW	65,973.04
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	21,975.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	21,975.96

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,710.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,239.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	87,949.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,949.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	199,303.27	ADJUSTMENTS	7,763.24
COVERED CHARGES	198,635.44	CONTRACTUAL ALLOW	92,868.81
NON-COVERD CHARGES	667.83	TOTAL MEDICAID LIAB	105,766.63
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	105,766.63

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	43	0	56,061.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	43	0	56,061.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	43	0	56,061.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,517.28	0.00
MED/SURG SUPPLY	6,951.69	0.00
LABORATORY-GENERAL	25,309.22	0.00
RADIOLOGY-DIAGNOSTIC	1,807.50	167.83
CT SCAN	14,041.73	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,124.36	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,971.35	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	33,751.03	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	504.98	0.00
SPEECH PATHOLOGY	325.87	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,085.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	383.27	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,280.00	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/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	688.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,832.16	500.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	142,574.44	667.83
TOTAL ACCOMODATIONS	56,061.00	0.00
TOTAL CHARGES	198,635.44	667.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	883,215.18	ADJUSTMENTS	70,320.11
COVERED CHARGES	853,518.03	CONTRACTUAL ALLOW	509,028.06
NON-COVERD CHARGES	29,697.15	TOTAL MEDICAID LIAB	344,489.97
		LESS: COB	162.17
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	344,327.80
		ALL OTHER	317,779.73
		FEE SCHEDULE-LAB	25,263.40
		INJECTABLE DRUGS	1,284.67

TOTAL NUMBER OF CLAIMS 502

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,590.03	1,175.89
MED/SURG SUPPLY	5,730.54	167.72
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,583.87	0.00
CT SCAN	115,580.92	7,074.75
PHYSICAL THERAPY	3,947.84	240.93
EKG/ECG	8,207.20	287.12
IV THERAPY	791.36	0.00
OPERATING ROOM	22,934.37	2,613.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,510.52	4,361.18
ANESTHESIA	7,155.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	458,011.18	3,115.89
RECOVERY ROOM	9,912.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	864.54	117.41
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	105.00	331.04
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	5,965.90	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	4,396.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	6,885.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,965.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	126,186.88	1,277.97
MRI SERVICES	4,846.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	44.66
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,009.91	8,889.59
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	337.50	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	853,518.03	29,697.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	853,518.03	29,697.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,731.72	ADJUSTMENTS	0.00
COVERED CHARGES	7,229.51	CONTRACTUAL ALLOW	4,444.96
NON-COVERD CHARGES	3,502.21	TOTAL MEDICAID LIAB	2,784.55
		LESS: COB	2,784.55
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	44.02
MED/SURG SUPPLY	127.62	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	111.05	0.00
CT SCAN	0.00	2,570.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	116.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,073.18	773.90
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 SERVICE	187.00	26.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,578.66	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.00	88.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,229.51	3,502.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,229.51	3,502.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,920.99	ADJUSTMENTS	280.00
COVERED CHARGES	55,245.37	CONTRACTUAL ALLOW	52,935.37
NON-COVERD CHARGES	1,675.62	TOTAL MEDICAID LIAB	2,310.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,310.00

TOTAL NUMBER OF CLAIMS 33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,229.96	0.00
MED/SURG SUPPLY	202.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,367.37	0.00
CT SCAN	4,759.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	140.12	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,216.15	963.89
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,471.54	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	858.48	711.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	55,245.37	1,675.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,245.37	1,675.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,277.63	ADJUSTMENTS	0.00
COVERED CHARGES	2,957.00	CONTRACTUAL ALLOW	2,887.00
NON-COVERD CHARGES	1,320.63	TOTAL MEDICAID LIAB	70.00
		LESS: COB	70.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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	1,315.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,850.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	607.00	5.63
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	500.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,957.00	1,320.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,957.00	1,320.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,526.04	ADJUSTMENTS	9,890.21
COVERED CHARGES	34,272.31	CONTRACTUAL ALLOW	24,382.10
NON-COVERD CHARGES	5,253.73	TOTAL MEDICAID LIAB	9,890.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	9,890.21

TOTAL NUMBER OF CLAIMS 2

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103.98	0.00
MED/SURG SUPPLY	9,618.19	79.45
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	8,239.52	0.00
OPERATING ROOM	12,919.23	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	4,583.25
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,008.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	525.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	669.69	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	713.70	66.03
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	34,272.31	5,253.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,272.31	5,253.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN COUNTY GEORGIA HOSPITAL AUTHORITY
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,035,936.33	ADJUSTMENTS	1,306,524.33
COVERED CHARGES	63,748,896.96	CONTRACTUAL ALLOW	53,257,463.77
NON-COVERD CHARGES	287,039.37	TOTAL MEDICAID LIAB	10,491,433.19
		LESS: COB	133,621.06
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	2,709.00
		REIMBURSEMENT	10,360,521.13

TOTAL NUMBER OF ADMISSIONS 990

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,716	0	6,780,124.00	0.00
ROUTINE NURSERY	342	0	817,598.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	47.00
TOTAL ROUTINE	4,058	0	7,597,722.00	47.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,249	0	6,595,184.00	0.00
NICU	34	0	213,214.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,283	0	6,808,398.00	0.00
TOTAL ACCOMODATIONS	5,341	0	14,406,120.00	47.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,287,232.65	0.00
MED/SURG SUPPLY	1,114,938.09	3,457.37
LABORATORY-GENERAL	11,576,541.50	0.00
RADIOLOGY-DIAGNOSTIC	880,997.00	0.00
CT SCAN	4,368,759.67	13,145.00
PHYSICAL THERAPY	442,126.00	0.00
EKG/ECG	553,553.00	0.00
IV THERAPY	1,513,364.00	0.00
OPERATING ROOM	3,901,863.00	0.00
LABOR/DELIVERY ROOM	309,042.00	558.00
RESPIRATORY SERVICES	5,509,225.00	0.00
ANESTHESIA	398,570.00	0.00
GI SERVICES	366,434.00	0.00
EMERGENCY ROOM	3,221,236.00	0.00
RECOVERY ROOM	522,719.00	0.00
LABORATORY PATHOLOGIC	271,495.00	0.00
RADIOLOGY THERAPEUTIC	190,084.00	0.00
OCCUPATIONAL THERAPY	398,791.00	0.00
SPEECH PATHOLOGY	162,511.00	0.00
RENAL DIALYSIS	1,771,921.00	5,606.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	20,162.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	412,729.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	573,390.00	234,378.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	157,417.08	29,848.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,275,441.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,889.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	227,935.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	491,940.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	724,382.18	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	659,088.29	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	49,342,776.96	286,992.37
TOTAL ACCOMODATIONS	14,406,120.00	47.00
TOTAL CHARGES	63,748,896.96	287,039.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,524,683.13	ADJUSTMENTS	0.00
COVERED CHARGES	1,521,236.13	CONTRACTUAL ALLOW	1,238,438.47
NON-COVERD CHARGES	3,447.00	TOTAL MEDICAID LIAB	282,797.66
		LESS: COB	283,868.66
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	1,071.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 52

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	104	0	189,696.00	0.00
ROUTINE NURSERY	46	0	87,442.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	150	0	277,138.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	15,881.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	15,881.00	0.00
TOTAL ACCOMODATIONS	153	0	293,019.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,242.06	0.00
MED/SURG SUPPLY	24,931.34	0.00
LABORATORY-GENERAL	197,833.00	0.00
RADIOLOGY-DIAGNOSTIC	18,185.00	0.00
CT SCAN	93,870.01	0.00
PHYSICAL THERAPY	5,285.00	0.00
EKG/ECG	5,530.00	0.00
IV THERAPY	27,274.00	0.00
OPERATING ROOM	200,121.00	0.00
LABOR/DELIVERY ROOM	128,566.00	558.00
RESPIRATORY SERVICES	3,892.00	0.00
ANESTHESIA	32,195.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	80,027.00	0.00
RECOVERY ROOM	87,812.00	0.00
LABORATORY PATHOLOGIC	7,165.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,767.00	0.00
SPEECH PATHOLOGY	3,752.00	0.00
RENAL DIALYSIS	50,454.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,757.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,404.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,544.00	2,694.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,065.00	195.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,310.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	28,095.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	13,357.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,011.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	8,772.72	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,228,217.13	3,447.00
TOTAL ACCOMODATIONS	293,019.00	0.00
TOTAL CHARGES	1,521,236.13	3,447.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,585,717.31	ADJUSTMENTS	162,583.98
COVERED CHARGES	21,081,109.27	CONTRACTUAL ALLOW	19,214,943.52
NON-COVERD CHARGES	3,504,608.04	TOTAL MEDICAID LIAB	1,866,165.75
		LESS: COB	5,592.03
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,860,573.72
		ALL OTHER	1,683,460.52
		FEE SCHEDULE-LAB	137,893.86
		INJECTABLE DRUGS	39,219.34

TOTAL NUMBER OF CLAIMS 3,611

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	300,948.72	2,400.94
MED/SURG SUPPLY	741,416.95	88,017.59
LABORATORY-GENERAL	0.00	360.00
RADIOLOGY-DIAGNOSTIC	613,783.00	31,830.00
CT SCAN	2,976,981.00	417,746.05
PHYSICAL THERAPY	99,634.00	29,464.00
EKG/ECG	299,726.00	5,530.00
IV THERAPY	1,478,370.00	171,832.00
OPERATING ROOM	2,237,907.10	389,174.90
LABOR/DELIVERY ROOM	5,292.00	0.00
RESPIRATORY SERVICES	106,264.00	52,884.00
ANESTHESIA	281,834.00	0.00
GI SERVICES	577,250.00	354,803.00
EMERGENCY ROOM	4,136,051.00	3,699.00
RECOVERY ROOM	584,001.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,046,517.00	202,079.00
OCCUPATIONAL THERAPY	45,004.00	33,519.00
SPEECH PATHOLOGY	8,460.00	14,126.00
RENAL DIALYSIS	0.00	308,330.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	465.00	2,170.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	72,284.00	0.00
OTHER IMAGING SERVICE	382,081.00	36,937.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	70,924.00	13,718.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	106,791.00	176,162.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	449,385.00	200,588.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	705,570.38	44,721.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	176,977.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	162.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,972,772.00	222,150.00
MRI SERVICES	252,417.00	143,795.02
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	312,540.81	235,520.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	39,462.31	301,813.25
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	21,076.00

TOTAL ANCILLARY	21,081,109.27	3,504,608.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,081,109.27	3,504,608.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022206019068	07/21/22 - 07/21/22	08/01/22	0.00	4,843.00	0.00	0.00	0.00
614	2022206019068	07/21/22 - 07/21/22	08/01/22	0.00	426.00	0.00	0.00	0.00
614	2022311026508	11/02/22 - 11/02/22	11/14/22	0.00	4,843.00	0.00	0.00	0.00
614	2022311026508	11/02/22 - 11/02/22	11/14/22	0.00	426.00	0.00	0.00	0.00
614	2023114012194	04/19/23 - 04/19/23	05/01/23	0.00	4,843.00	0.00	0.00	0.00
614	2023114012194	04/19/23 - 04/19/23	05/01/23	0.00	426.00	0.00	0.00	0.00
614	2023184014741	06/28/23 - 06/28/23	07/10/23	0.00	4,843.00	0.00	0.00	0.00
614	2023184014741	06/28/23 - 06/28/23	07/10/23	0.00	426.00	0.00	0.00	0.00
TOTAL				0.00	21,076.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	459,701.64	ADJUSTMENTS	0.00
COVERED CHARGES	380,381.16	CONTRACTUAL ALLOW	348,025.78
NON-COVERD CHARGES	79,320.48	TOTAL MEDICAID LIAB	32,355.38
		LESS: COB	32,355.38
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,616.75	665.60
MED/SURG SUPPLY	10,102.77	1,138.23
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,170.00	0.00
CT SCAN	12,575.00	43,854.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,530.00	0.00
IV THERAPY	30,318.00	6,755.00
OPERATING ROOM	67,173.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,029.00	0.00
ANESTHESIA	6,074.00	0.00
GI SERVICES	3,941.00	0.00
EMERGENCY ROOM	104,305.00	0.00
RECOVERY ROOM	20,478.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	155.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	7,947.00	4,056.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,098.00	1,143.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	14,702.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	7,340.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60,739.00	6,479.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,242.64	6,420.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	8,653.96
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	380,381.16	79,320.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	380,381.16	79,320.48

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,702,650.27	ADJUSTMENTS	402.78
COVERED CHARGES	1,638,797.93	CONTRACTUAL ALLOW	1,612,818.62
NON-COVERD CHARGES	63,852.34	TOTAL MEDICAID LIAB	25,979.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	25,979.31

TOTAL NUMBER OF CLAIMS 387

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,731.80	166.40
MED/SURG SUPPLY	1,618.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,196.00	1,426.00
CT SCAN	327,538.00	18,848.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	34,839.00	1,106.00
IV THERAPY	123,459.00	22,352.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	929.00	857.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	718,309.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	19,018.00	1,841.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	4,015.85	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	9,175.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	272,902.00	9,308.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,067.28	7,947.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,638,797.93	63,852.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,638,797.93	63,852.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,988.84	ADJUSTMENTS	0.00
COVERED CHARGES	35,637.17	CONTRACTUAL ALLOW	35,100.13
NON-COVERD CHARGES	351.67	TOTAL MEDICAID LIAB	537.04
		LESS: COB	537.04
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	224.64	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,939.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.00	0.00
IV THERAPY	6,289.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,586.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,835.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,192.00	225.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18.53	126.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	35,637.17	351.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,637.17	351.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,299,352.19	ADJUSTMENTS	28,563.89
COVERED CHARGES	1,192,191.67	CONTRACTUAL ALLOW	1,089,361.59
NON-COVERD CHARGES	107,160.52	TOTAL MEDICAID LIAB	102,830.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	102,830.08

TOTAL NUMBER OF CLAIMS 18

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,311.06	0.00
MED/SURG SUPPLY	123,193.55	6,443.31
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,527.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	2,284.00	0.00
OPERATING ROOM	280,886.67	17,989.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,914.00	0.00
ANESTHESIA	56,289.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,110.00	0.00
RECOVERY ROOM	74,007.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	7,302.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	126,442.00	34,145.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	1,826.65	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,247.00	4,609.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	303,297.22	16,966.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	158,554.52	27,007.04
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,192,191.67	107,160.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,192,191.67	107,160.52

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	489,078.27	ADJUSTMENTS	179,978.36
COVERED CHARGES	489,078.27	CONTRACTUAL ALLOW	279,850.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	209,228.27
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	209,228.27

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	211	0	240,395.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	211	0	240,395.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	211	0	240,395.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,143.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,073.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,061.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,295.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,140.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,455.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,016.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,499.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	248,683.27	0.00
TOTAL ACCOMODATIONS	240,395.00	0.00
TOTAL CHARGES	489,078.27	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REHABILITATION HOSPITAL OF SAVANNAH
6510 SEAWRIGHT DRIVE
SAVANNAH,GA 31406-2752

PROVIDER NUMBER
003161381A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/22 THROUGH 03/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	676,814.25	ADJUSTMENTS	31,810.15
COVERED CHARGES	671,369.25	CONTRACTUAL ALLOW	452,866.36
NON-COVERD CHARGES	5,445.00	TOTAL MEDICAID LIAB	218,502.89
		LESS: COB	1,054.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	217,448.81

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	67	0	90,848.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	90,848.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	67	0	90,848.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,846.25	2.00	OTHER LAB	2,391.00	0.00
MED/SURG SUPPLY	370.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	151,585.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	118,147.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,627.00	2,336.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,378.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,080.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,906.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,070.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,343.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,026.00	707.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,524.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,641.00	476.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,861.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,726.00	1,924.00			

TOTAL ANCILLARY	580,521.25	5,445.00
TOTAL ACCOMODATIONS	90,848.00	0.00
TOTAL CHARGES	671,369.25	5,445.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/22	THROUGH	06/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,600,786.00	ADJUSTMENTS	150,862.45
COVERED CHARGES	3,897,525.00	CONTRACTUAL ALLOW	3,274,071.99
NON-COVERD CHARGES	703,261.00	TOTAL MEDICAID LIAB	623,453.01
		LESS: COB	4,271.47
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	619,181.54
		ALL OTHER	552,735.09
		FEE SCHEDULE-LAB	60,513.30
		INJECTABLE DRUGS	5,933.15

TOTAL NUMBER OF CLAIMS 976

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,385.75	19,450.59
MED/SURG SUPPLY	789.30	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250,804.41	8,240.90
CT SCAN	580,417.24	434,380.80
PHYSICAL THERAPY	0.00	1,330.00
EKG/ECG	184,747.67	7,482.89
IV THERAPY	18,877.68	0.00
OPERATING ROOM	423.00	2,970.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37,127.72	861.14
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,620,613.70	902.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	141,131.00	35,004.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,446.00	3,120.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	11,155.00	1,541.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,786.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,440.00	62,494.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,172.00	26,520.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	57,129.68	24,272.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,963.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	890,469.49	44,238.82
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,646.36	30,452.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,897,525.00	703,261.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,897,525.00	703,261.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,411.50	ADJUSTMENTS	0.00
COVERED CHARGES	70,264.00	CONTRACTUAL ALLOW	59,486.38
NON-COVERD CHARGES	10,147.50	TOTAL MEDICAID LIAB	10,777.62
		LESS: COB	10,777.62
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	97.75
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	916.00	0.00
CT SCAN	6,485.00	7,456.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,720.00	0.00
IV THERAPY	6,132.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,910.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	677.00	783.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	2,664.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,555.00	1,008.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,205.00	802.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	70,264.00	10,147.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,264.00	10,147.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	349,118.75	ADJUSTMENTS	1,006.95
COVERED CHARGES	315,680.00	CONTRACTUAL ALLOW	307,020.23
NON-COVERD CHARGES	33,438.75	TOTAL MEDICAID LIAB	8,659.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	8,659.77

TOTAL NUMBER OF CLAIMS 129

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	689.50	314.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,503.00	0.00
CT SCAN	28,303.00	27,040.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,778.00	680.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	190,341.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,354.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,040.00	3,644.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,671.50	1,760.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	315,680.00	33,438.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	315,680.00	33,438.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,774.25	ADJUSTMENTS	0.00
COVERED CHARGES	7,705.50	CONTRACTUAL ALLOW	7,436.98
NON-COVERD CHARGES	68.75	TOTAL MEDICAID LIAB	268.52
		LESS: COB	268.52
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	4.75
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	458.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	680.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,432.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,121.00	54.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.50	10.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	7,705.50	68.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,705.50	68.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,820.00	ADJUSTMENTS	5,086.30
COVERED CHARGES	470,710.00	CONTRACTUAL ALLOW	440,192.20
NON-COVERD CHARGES	2,110.00	TOTAL MEDICAID LIAB	30,517.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	30,517.80

TOTAL NUMBER OF CLAIMS 6

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	470,384.00	2,110.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	326.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	470,710.00	2,110.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	470,710.00	2,110.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/22 THROUGH 06/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,111,106.87	ADJUSTMENTS	381,898.47
COVERED CHARGES	2,091,980.43	CONTRACTUAL ALLOW	1,518,412.16
NON-COVERD CHARGES	19,126.44	TOTAL MEDICAID LIAB	573,568.27
		LESS: COB	2,290.77
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	571,277.50

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	390	0	997,164.00	0.00
ROUTINE NURSERY	8	0	20,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	398	0	1,017,964.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	398	0	1,017,964.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,606.10	0.00
MED/SURG SUPPLY	10,375.19	0.00
LABORATORY-GENERAL	135,434.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	255,661.00	0.00
EKG/ECG	816.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	98,527.00	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	77.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	262,087.00	0.00
SPEECH PATHOLOGY	96,087.00	0.00
RENAL DIALYSIS	9,995.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	11,866.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	39,387.00	0.00
EDUCATION & TRAINING	115.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	19,126.44
INJECTABLE DRUGS	94,983.14	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,074,016.43	19,126.44
TOTAL ACCOMODATIONS	1,017,964.00	0.00
TOTAL CHARGES	2,091,980.43	19,126.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,859.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,859.00	CONTRACTUAL ALLOW	1,494.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	364.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	364.19
		ALL OTHER	364.19
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,859.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,859.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,859.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ES REHABILITATION, LLC
1441 CLIFTON ROAD NE
ATLANTA,GA 30322-1004

PROVIDER NUMBER
003212414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,265,486.62	ADJUSTMENTS	736,415.53
COVERED CHARGES	3,253,984.55	CONTRACTUAL ALLOW	1,649,377.39
NON-COVERD CHARGES	11,502.07	TOTAL MEDICAID LIAB	1,604,607.16
		LESS: COB	23,082.80
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	1,581,524.36

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,114	0	1,137,394.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.07
TOTAL ROUTINE	1,114	0	1,137,394.00	0.07
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,114	0	1,137,394.00	0.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,075.78	0.00
MED/SURG SUPPLY	37.80	0.00
LABORATORY-GENERAL	224,618.50	0.00
RADIOLOGY-DIAGNOSTIC	3,764.05	0.00
CT SCAN	16,186.92	0.00
PHYSICAL THERAPY	586,410.00	0.00
EKG/ECG	10,494.15	0.00
IV THERAPY	176.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	302,125.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,506.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	586,360.70	0.00
SPEECH PATHOLOGY	98,257.30	0.00
RENAL DIALYSIS	15,644.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,771.20	2,161.10
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,369.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	2,302.30	0.00
RECREATIONAL THERAPY	10,494.30	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	357.75	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,340.90
INJECTABLE DRUGS	157,638.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,116,590.55	11,502.00
TOTAL ACCOMODATIONS	1,137,394.00	0.07
TOTAL CHARGES	3,253,984.55	11,502.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2023208043185	06/22/23 - 07/11/23	07/31/23	0.00	0.00	0.00	0.00	0.00
24	2023213051400	06/12/23 - 07/07/23	08/07/23	0.00	0.00	0.00	0.00	0.00
24	2023216087135	07/24/23 - 07/27/23	08/14/23	0.00	0.00	0.00	0.00	0.00
24	2023219018664	07/19/23 - 08/02/23	08/14/23	0.00	0.00	0.00	0.00	0.00
24	2023219018674	07/15/23 - 07/28/23	08/14/23	0.00	0.00	0.00	0.00	0.00
24	2023233021668	07/21/23 - 07/26/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000674	01/09/23 - 01/24/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000675	01/05/23 - 01/19/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000676	01/09/23 - 01/26/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000686	01/26/23 - 02/02/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000700	01/27/23 - 02/09/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000706	01/24/23 - 02/10/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000710	01/23/23 - 02/06/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000732	02/10/23 - 02/22/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000752	02/02/23 - 02/20/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000769	02/13/23 - 03/01/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000782	02/14/23 - 02/28/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000799	03/13/23 - 03/27/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000800	03/09/23 - 03/31/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000810	03/17/23 - 03/31/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000831	01/26/23 - 02/09/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000864	03/30/23 - 04/11/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000906	04/05/23 - 04/20/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000937	05/15/23 - 05/23/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000938	05/01/23 - 05/19/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000939	05/10/23 - 05/25/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000940	05/03/23 - 05/16/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000941	04/26/23 - 05/11/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000984	05/23/23 - 06/02/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233000985	05/19/23 - 06/01/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001015	03/31/23 - 04/17/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001017	06/12/23 - 06/13/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001034	05/23/23 - 06/16/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001038	04/19/23 - 05/02/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001039	05/31/23 - 06/14/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	5223233001066	06/21/23 - 07/10/23	08/28/23	0.00	0.00	0.00	0.00	0.00
24	2023240007879	08/10/23 - 08/21/23	09/04/23	0.00	0.00	0.00	0.00	0.00
24	2023242061971	06/20/23 - 06/29/23	09/04/23	0.00	0.00	0.00	0.00	0.00
24	2023244040036	08/18/23 - 08/23/23	09/04/23	0.00	0.00	0.00	0.00	0.00
24	2023249010528	06/11/23 - 06/23/23	09/11/23	0.00	0.00	0.00	0.00	0.00
24	5923249001202	05/31/23 - 06/23/23	09/11/23	0.00	0.00	0.00	0.00	0.00
24	2023267002849	09/06/23 - 09/20/23	10/02/23	0.00	0.00	0.00	0.00	0.00

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

24	2023268008090	09/01/23 - 09/21/23	10/02/23	0.00	0.00	0.00	0.00	0.00
24	2023269070526	09/12/23 - 09/22/23	10/02/23	0.00	0.00	0.00	0.00	0.00
24	2023269070567	09/08/23 - 09/22/23	10/02/23	0.00	0.00	0.00	0.00	0.00
24	2023277065040	08/16/23 - 08/25/23	10/09/23	0.00	0.00	0.00	0.00	0.00
24	2023277065051	08/31/23 - 09/11/23	10/09/23	0.00	0.00	0.00	0.00	0.00
24	2023289018822	09/14/23 - 10/11/23	10/23/23	0.00	0.00	0.00	0.00	0.00
24	2023296030490	10/02/23 - 10/17/23	10/30/23	0.00	0.00	0.00	0.00	0.00
24	2023297083504	09/07/23 - 09/28/23	10/30/23	0.00	0.00	0.00	0.00	0.00
24	2023297083584	10/06/23 - 10/19/23	10/30/23	0.00	0.00	0.00	0.00	0.00
24	2023318050382	10/20/23 - 11/10/23	11/20/23	0.00	0.00	0.00	0.00	0.00
24	2023320054118	10/19/23 - 11/08/23	11/20/23	0.00	0.00	0.00	0.00	0.00
24	2023321059349	10/25/23 - 11/13/23	11/20/23	0.00	0.00	0.00	0.00	0.00
24	2023345022872	11/14/23 - 12/04/23	12/18/23	0.00	0.00	0.00	0.00	0.00
24	2023346022879	11/07/23 - 11/30/23	12/18/23	0.00	0.00	0.00	0.00	0.00
24	2023361045420	11/27/23 - 12/05/23	01/01/24	0.00	0.00	0.00	0.00	0.00
24	9724009957034	02/14/23 - 03/03/23	01/15/24	0.00	0.00	0.00	0.00	0.00
24	2024013008917	12/18/23 - 12/23/23	01/22/24	0.00	0.00	0.00	0.00	0.00
24	2024050031355	06/08/23 - 06/20/23	02/26/24	0.00	0.00	0.00	0.00	0.00
24	5924052001276	10/30/23 - 11/14/23	02/26/24	0.00	0.00	0.00	0.00	0.00
24	2024056003110	01/11/23 - 01/23/23	03/04/24	0.00	0.00	0.00	0.00	0.00
24	2024107025092	12/15/23 - 12/31/23	04/22/24	0.00	0.00	0.00	0.00	0.00
24	2024255022637	09/22/23 - 10/20/23	09/16/24	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/23	THROUGH	12/31/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	604,707.65	ADJUSTMENTS	9,669.09
COVERED CHARGES	567,168.40	CONTRACTUAL ALLOW	418,948.52
NON-COVERD CHARGES	37,539.25	TOTAL MEDICAID LIAB	148,219.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	148,219.88
		ALL OTHER	148,215.42
		FEE SCHEDULE-LAB	4.46
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 482

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	115.55
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	431,927.70	17,085.35	FEE SCHEDULE LAB	51.95	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	130,465.25	13,100.55	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,723.50	7,237.80	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	567,168.40	37,539.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	567,168.40	37,539.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,843.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,328.95	CONTRACTUAL ALLOW	984.50
NON-COVERD CHARGES	44,514.15	TOTAL MEDICAID LIAB	344.45
		LESS: COB	344.45
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	848.70	1,064.85	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,464.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	41,590.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	430.25	394.80	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,328.95	44,514.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,328.95	44,514.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CENTRAL GEORGIA REHABILITATION HOSPITAL, LLC
3351 NORTHSIDE DRIVE
MACON,GA 31210-2587

PROVIDER NUMBER
003213433A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,198,917.31	ADJUSTMENTS	1,510,300.37
COVERED CHARGES	4,186,298.31	CONTRACTUAL ALLOW	1,758,000.50
NON-COVERD CHARGES	12,619.00	TOTAL MEDICAID LIAB	2,428,297.81
		LESS: COB	12,742.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,415,555.73

TOTAL NUMBER OF ADMISSIONS 126

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,685	0	2,064,405.10	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,685	0	2,064,405.10	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,685	0	2,064,405.10	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	606,930.81	0.00	OTHER LAB	16,672.00	0.00
MED/SURG SUPPLY	118,424.00	278.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	74,666.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,055.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,728.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	581,329.40	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,645.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	10,613.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	576,993.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,787.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	16,762.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,009.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,398.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,221.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,121,893.21	12,619.00
TOTAL ACCOMODATIONS	2,064,405.10	0.00
TOTAL CHARGES	4,186,298.31	12,619.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HEALTHCARE EHRH OF NEWNAN LLC
2101 E. NEWNAN CROSSING BLVD
NEWNAN,GA 30265-2406

PROVIDER NUMBER
003213641A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,566,576.07	ADJUSTMENTS	812,088.83
COVERED CHARGES	5,565,926.07	CONTRACTUAL ALLOW	1,916,172.22
NON-COVERD CHARGES	650.00	TOTAL MEDICAID LIAB	3,649,753.85
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	3,649,753.85

TOTAL NUMBER OF ADMISSIONS 52

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,935	0	1,309,130.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	650.00
TOTAL ROUTINE	1,935	0	1,309,130.00	650.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	29	0	19,807.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	29	0	19,807.00	0.00
TOTAL ACCOMODATIONS	1,964	0	1,328,937.00	650.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	854,803.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	387,936.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	310,859.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,283.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,507.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,251.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,156,847.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,083,069.47	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,311.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	25,252.40	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	233,600.40	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	2,903.45	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,325.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,236,989.07	0.00
TOTAL ACCOMODATIONS	1,328,937.00	650.00
TOTAL CHARGES	5,565,926.07	650.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AFFABILIS, LLC
616 19TH STREET
COLUMBUS,GA 31901-1528

PROVIDER NUMBER
003213968A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/23 THROUGH 12/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,051,282.00	ADJUSTMENTS	50,892.50
COVERED CHARGES	2,025,777.00	CONTRACTUAL ALLOW	1,677,833.52
NON-COVERD CHARGES	25,505.00	TOTAL MEDICAID LIAB	347,943.48
		LESS: COB	11,641.68
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	336,301.80

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	215	0	365,715.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	215	0	365,715.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	215	0	365,715.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,509.00	25,505.00
MED/SURG SUPPLY	1,108.00	0.00
LABORATORY-GENERAL	410,050.00	0.00
RADIOLOGY-DIAGNOSTIC	21,476.00	0.00
CT SCAN	237,560.00	0.00
PHYSICAL THERAPY	7,287.00	0.00
EKG/ECG	24,644.00	0.00
IV THERAPY	186,971.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31,024.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	160,078.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	1,259.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	30,225.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	405.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	57,829.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	83,265.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	10,860.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,512.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	1,660,062.00	25,505.00
TOTAL ACCOMODATIONS	365,715.00	0.00
TOTAL CHARGES	2,025,777.00	25,505.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,799.00	ADJUSTMENTS	0.00
COVERED CHARGES	41,799.00	CONTRACTUAL ALLOW	33,814.23
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,984.77
		LESS: COB	7,984.77
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	1,701.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	1,701.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	1,701.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,914.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,554.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	352.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,915.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	404.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,562.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,263.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	1,905.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,520.00	0.00			

TOTAL ANCILLARY	40,098.00	0.00
TOTAL ACCOMODATIONS	1,701.00	0.00
TOTAL CHARGES	41,799.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,083,834.00	ADJUSTMENTS	16,073.03
COVERED CHARGES	2,724,716.00	CONTRACTUAL ALLOW	2,374,931.31
NON-COVERD CHARGES	359,118.00	TOTAL MEDICAID LIAB	349,784.69
		LESS: COB	7.81
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	349,776.88
		ALL OTHER	308,734.35
		FEE SCHEDULE-LAB	38,143.17
		INJECTABLE DRUGS	2,899.36

TOTAL NUMBER OF CLAIMS 495

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,233.00	50,867.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,921.00	1,300.00
CT SCAN	640,639.00	103,186.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	67,064.00	0.00
IV THERAPY	272,591.00	323.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29,262.00	4,637.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	872,494.00	867.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	846.00	282.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	26,187.00	8,022.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,037.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,469.00	12,205.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	25,200.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	38,569.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	513,643.00	75,899.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	76,561.00	101,530.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	2,724,716.00	359,118.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,724,716.00	359,118.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,452.00	ADJUSTMENTS	0.00
COVERED CHARGES	53,866.00	CONTRACTUAL ALLOW	47,513.42
NON-COVERD CHARGES	9,586.00	TOTAL MEDICAID LIAB	6,352.58
		LESS: COB	6,352.58
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	347.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,121.00	1,332.00
CT SCAN	12,370.00	6,185.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	808.00	0.00
IV THERAPY	2,887.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,335.00	1,204.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	3,477.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,350.00	422.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,518.00	96.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	53,866.00	9,586.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,866.00	9,586.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,572.00	ADJUSTMENTS	0.00
COVERED CHARGES	64,203.00	CONTRACTUAL ALLOW	62,088.36
NON-COVERD CHARGES	3,369.00	TOTAL MEDICAID LIAB	2,114.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	2,114.64

TOTAL NUMBER OF CLAIMS 27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	19.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,937.00	0.00
CT SCAN	4,768.00	2,070.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	808.00	0.00
IV THERAPY	2,087.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,266.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,673.00	1,019.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	664.00	261.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	64,203.00	3,369.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,203.00	3,369.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,656.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,616.00	CONTRACTUAL ALLOW	5,459.36
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	156.64
		LESS: COB	156.64
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	352.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,028.00	39.00
EKG/ECG	404.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	816.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,744.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272.00	1.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,616.00	40.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,616.00	40.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,158.00	ADJUSTMENTS	0.00
COVERED CHARGES	38,471.00	CONTRACTUAL ALLOW	33,384.70
NON-COVERD CHARGES	687.00	TOTAL MEDICAID LIAB	5,086.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	5,086.30

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	56.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	352.00	0.00
CT SCAN	9,803.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	404.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,727.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,619.00	388.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,566.00	243.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	38,471.00	687.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,471.00	687.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NGMC LUMPKIN, LLC
495 HIGHWAY 400
DAHLONEGA,GA 30533-6223

PROVIDER NUMBER
003229414A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	539,009.93	ADJUSTMENTS	203,198.80
COVERED CHARGES	539,009.93	CONTRACTUAL ALLOW	260,872.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	278,137.37
		LESS: COB	1,500.63
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	276,636.74

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	193	0	291,612.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	193	0	291,612.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	193	0	291,612.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,021.02	0.00	OTHER LAB	4,050.00	0.00
MED/SURG SUPPLY	4,472.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,712.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,530.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,007.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,831.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,796.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	64,785.90	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,192.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	247,397.93	0.00
TOTAL ACCOMODATIONS	291,612.00	0.00
TOTAL CHARGES	539,009.93	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/22	THROUGH	09/30/23
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTH S REHAB HOSP OF FORSYTH CTY, LLC
1165 SANDERS ROAD
CUMMING,GA 30041-5965

PROVIDER NUMBER
003257339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/22 THROUGH 09/30/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,759,289.60	ADJUSTMENTS	240,018.98
COVERED CHARGES	10,653,176.55	CONTRACTUAL ALLOW	8,243,266.12
NON-COVERD CHARGES	106,113.05	TOTAL MEDICAID LIAB	2,409,910.43
		LESS: COB	21,413.75
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	63.00
		REIMBURSEMENT	2,388,559.68

TOTAL NUMBER OF ADMISSIONS 254

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,027	0	1,861,734.00	0.00
ROUTINE NURSERY	219	0	800,254.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,246	0	2,661,988.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	135	0	927,884.00	0.00
NICU	5	0	39,857.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	140	0	967,741.00	0.00
TOTAL ACCOMODATIONS	1,386	0	3,629,729.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	575,624.91	0.00
MED/SURG SUPPLY	229,109.69	0.00
LABORATORY-GENERAL	1,544,878.81	0.00
RADIOLOGY-DIAGNOSTIC	193,829.00	0.00
CT SCAN	399,954.00	2,450.00
PHYSICAL THERAPY	93,983.00	0.00
EKG/ECG	46,512.00	0.00
IV THERAPY	56,623.00	0.00
OPERATING ROOM	680,727.01	0.00
LABOR/DELIVERY ROOM	87,689.00	562.00
RESPIRATORY SERVICES	395,897.01	0.00
ANESTHESIA	151,482.00	0.00
GI SERVICES	74,337.00	0.00
EMERGENCY ROOM	506,221.00	0.00
RECOVERY ROOM	108,204.00	0.00
LABORATORY PATHOLOGIC	61,763.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	84,320.00	0.00
SPEECH PATHOLOGY	72,461.00	0.00
RENAL DIALYSIS	43,824.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,029.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	87,007.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	51,414.00	66,515.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,886.00	3,584.72
AUDIOLOGY	13,771.00	0.00
CARDIOLOGY	463,530.00	1,489.00
AMBULATORY SURGERY	903.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,769.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	273,482.00	15,160.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	88,092.00	1,956.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	115.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	104,898.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	9,450.51
INJECTABLE DRUGS	337,651.84	4,945.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	134,340.28	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	38,120.00	0.00

TOTAL ANCILLARY	7,023,447.55	106,113.05
TOTAL ACCOMODATIONS	3,629,729.00	0.00
TOTAL CHARGES	10,653,176.55	106,113.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
615	2022292121841	10/01/22 - 10/04/22	10/24/22	7,624.00	0.00	0.00	0.00	0.00
615	2022292122689	10/10/22 - 10/14/22	10/24/22	3,812.00	0.00	0.00	0.00	0.00
615	2223033002419	12/16/22 - 12/19/22	02/06/23	7,624.00	0.00	0.00	0.00	0.00
614	2223034014042	01/02/23 - 01/04/23	02/06/23	3,812.00	0.00	0.00	0.00	0.00
614	5223058000345	11/23/22 - 12/06/22	03/06/23	7,624.00	0.00	0.00	0.00	0.00
615	2324031000302	06/07/23 - 06/30/23	03/04/24	7,624.00	0.00	0.00	0.00	0.00
TOTAL				38,120.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	292,200.71	ADJUSTMENTS	0.00
COVERED CHARGES	292,200.71	CONTRACTUAL ALLOW	229,567.63
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	62,633.08
		LESS: COB	62,822.08
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	189.00
		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	32	0	57,824.00	0.00
ROUTINE NURSERY	15	0	23,730.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	81,554.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	47	0	81,554.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,853.83	0.00
MED/SURG SUPPLY	3,745.68	0.00
LABORATORY-GENERAL	38,208.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	10,195.00	0.00
PHYSICAL THERAPY	417.00	0.00
EKG/ECG	408.00	0.00
IV THERAPY	1,593.00	0.00
OPERATING ROOM	2,618.00	0.00
LABOR/DELIVERY ROOM	90,611.00	0.00
RESPIRATORY SERVICES	3,648.00	0.00
ANESTHESIA	15,713.00	0.00
GI SERVICES	2,239.00	0.00
EMERGENCY ROOM	8,676.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	1,539.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	483.00	0.00
SPEECH PATHOLOGY	1,203.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	776.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	1,876.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,344.00	0.00
CARDIOLOGY	3,497.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,296.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,555.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	210,646.71	0.00
TOTAL ACCOMODATIONS	81,554.00	0.00
TOTAL CHARGES	292,200.71	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,386,986.53	ADJUSTMENTS	31,813.71
COVERED CHARGES	2,729,696.89	CONTRACTUAL ALLOW	2,217,863.46
NON-COVERD CHARGES	657,289.64	TOTAL MEDICAID LIAB	511,833.43
		LESS: COB	5,662.66
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	506,170.77
		ALL OTHER	469,072.86
		FEE SCHEDULE-LAB	33,752.37
		INJECTABLE DRUGS	3,345.54

TOTAL NUMBER OF CLAIMS 765

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,724.57	35,658.64
MED/SURG SUPPLY	74,310.66	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,644.00	13,911.00
CT SCAN	242,368.00	124,776.00
PHYSICAL THERAPY	4,101.00	3,485.00
EKG/ECG	37,128.00	816.00
IV THERAPY	112,139.00	6,453.00
OPERATING ROOM	215,099.50	162,671.50
LABOR/DELIVERY ROOM	891.00	0.00
RESPIRATORY SERVICES	39,648.00	1,104.00
ANESTHESIA	72,135.00	0.00
GI SERVICES	963.00	25,107.00
EMERGENCY ROOM	618,261.00	4,280.00
RECOVERY ROOM	68,273.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,877.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	108.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	217,068.00	37,601.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,493.00	42,524.17
AUDIOLOGY	0.00	0.00
CARDIOLOGY	87,501.00	83,532.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	133,158.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	98,634.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	83,953.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	364,410.00	25,014.00
MRI SERVICES	86,204.00	21,356.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,631.34	22,335.17
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	7,808.82	36,056.16
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	36,150.00	7,624.00

TOTAL ANCILLARY	2,729,696.89	657,289.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,729,696.89	657,289.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
614	2022354029609	12/15/22 - 12/15/22	12/26/22	3,812.00	0.00	0.00	0.00	764.69
614	2023010058279	01/07/23 - 01/07/23	01/16/23	3,812.00	0.00	0.00	0.00	764.69
614	2023010058279	01/07/23 - 01/07/23	01/16/23	3,812.00	0.00	0.00	0.00	764.69
614	5923011000791	11/18/22 - 11/18/22	01/16/23	3,358.00	0.00	0.00	0.00	673.62
615	2023030040051	12/27/22 - 12/27/22	02/06/23	0.00	3,812.00	0.00	0.00	0.00
615	2023030040051	12/27/22 - 12/27/22	02/06/23	3,812.00	0.00	0.00	0.00	764.69
615	2023072046521	02/08/23 - 02/08/23	03/20/23	0.00	3,812.00	0.00	0.00	0.00
615	2023072046521	02/08/23 - 02/08/23	03/20/23	3,812.00	0.00	0.00	0.00	764.69
614	2023080038204	03/15/23 - 03/15/23	03/27/23	3,812.00	0.00	0.00	0.00	764.69
614	2223114005526	04/07/23 - 04/07/23	05/01/23	2,296.00	0.00	0.00	0.00	460.58
614	2023117100076	04/24/23 - 04/24/23	05/01/23	3,812.00	0.00	0.00	0.00	764.69
615	2023125098290	04/04/23 - 04/04/23	05/15/23	3,812.00	0.00	0.00	0.00	764.69
TOTAL				36,150.00	7,624.00	0.00	0.00	7,251.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	173,205.58	ADJUSTMENTS	0.00
COVERED CHARGES	105,243.20	CONTRACTUAL ALLOW	87,450.51
NON-COVERD CHARGES	67,962.38	TOTAL MEDICAID LIAB	17,792.69
		LESS: COB	17,792.69
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	649.83	974.37
MED/SURG SUPPLY	5,822.18	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,426.00	751.00
CT SCAN	4,780.00	13,987.00
PHYSICAL THERAPY	0.00	1,047.00
EKG/ECG	0.00	0.00
IV THERAPY	7,146.00	0.00
OPERATING ROOM	3,522.25	13,899.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,437.00	1,181.00
ANESTHESIA	4,185.00	0.00
GI SERVICES	0.00	10,053.00
EMERGENCY ROOM	25,217.00	934.00
RECOVERY ROOM	1,435.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,500.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,756.00	2,851.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	6,208.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,776.00	6,994.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	3,040.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	4,545.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,546.00	2,620.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,959.94	2,119.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	2,842.55
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	105,243.20	67,962.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,243.20	67,962.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	179,685.90	ADJUSTMENTS	67.13
COVERED CHARGES	165,012.65	CONTRACTUAL ALLOW	160,850.59
NON-COVERD CHARGES	14,673.25	TOTAL MEDICAID LIAB	4,162.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	4,162.06

TOTAL NUMBER OF CLAIMS 62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.40	1,329.55
MED/SURG SUPPLY	352.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,687.00	1,790.00
CT SCAN	26,969.00	6,982.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,856.00	0.00
IV THERAPY	10,867.00	408.00
OPERATING ROOM	404.00	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	90,975.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	990.00	810.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	684.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,702.00	2,086.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	527.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	473.25	740.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	0.00	0.00
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	165,012.65	14,673.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	165,012.65	14,673.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,904.81	ADJUSTMENTS	0.00
COVERED CHARGES	4,831.81	CONTRACTUAL ALLOW	4,630.42
NON-COVERD CHARGES	73.00	TOTAL MEDICAID LIAB	201.39
		LESS: COB	201.39
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	643.00	73.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,096.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92.81	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	GENE THERAPY DRUGS	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,831.81	73.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,831.81	73.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	350,475.09	ADJUSTMENTS	16,654.92
COVERED CHARGES	281,382.10	CONTRACTUAL ALLOW	242,520.41
NON-COVERD CHARGES	69,092.99	TOTAL MEDICAID LIAB	38,861.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		ADD: ADDON PYMT	0.00
		REIMBURSEMENT	38,861.69

TOTAL NUMBER OF CLAIMS 7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
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EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
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PROVIDER NUMBER
344886600A

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PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,709.99	1,046.81
MED/SURG SUPPLY	20,052.28	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,461.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	3,983.00
EKG/ECG	1,428.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	134,746.00	14,043.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	33,734.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	26,251.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,176.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,604.00	19,714.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	5,776.00	1,395.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	1,881.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,981.00	487.00
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,289.17	287.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	16,468.66	23,960.71
GENE THERAPY DRUGS	0.00	0.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	281,382.10	69,092.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	281,382.10	69,092.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JOHNS CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/22 THROUGH 08/31/23
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA FOUND **

** END OF REPORT **