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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,478,504.45	ADJUSTMENTS	15,358.54
COVERED CHARGES	2,360,579.74	CONTRACTUAL ALLOW	1,258,271.91
NON-COVERD CHARGES	117,924.71	TOTAL MEDICAID LIAB	1,102,307.83
		LESS: COB	10,963.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,091,344.39

TOTAL NUMBER OF ADMISSIONS 204

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,361	0	677,778.00	84,840.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,361	0	677,778.00	84,840.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	92	0	101,518.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	101,518.00	0.00
TOTAL ACCOMODATIONS	1,453	0	779,296.00	84,840.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	196,752.60	0.00	OTHER LAB	1,381.00	0.00
MED/SURG SUPPLY	67,339.39	45.43	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	488,262.00	1,458.00	EDUCATION & TRAINING	56.00	0.00
RADIOLOGY-DIAGNOSTIC	24,788.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,015.00	5,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,195.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,210.00	0.00	MRI SERVICES	13,511.00	0.00
IV THERAPY	187,801.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,211.00	9,386.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,745.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,046.00	2,920.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	278,886.00	435.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	317.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,437.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,260.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,225.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,778.00	13,140.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,550.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	836.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,727.00	0.00			

TOTAL ANCILLARY	1,581,283.74	33,084.71
TOTAL ACCOMODATIONS	779,296.00	84,840.00
TOTAL CHARGES	2,360,579.74	117,924.71

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,338,209.29	ADJUSTMENTS	78,746.51
COVERED CHARGES	1,250,446.48	CONTRACTUAL ALLOW	924,138.74
NON-COVERD CHARGES	87,762.81	TOTAL MEDICAID LIAB	326,307.74
		LESS: COB	172.60
		LESS: COPAYMENT	975.00
		REIMBURSEMENT	325,160.14
		ALL OTHER	268,839.95
		FEE SCHEDULE-LAB	34,990.59
		INJECTABLE DRUGS	21,329.60

TOTAL NUMBER OF CLAIMS 1,010

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,574.26	34.50	OTHER LAB	4,185.00	0.00
MED/SURG SUPPLY	34,519.33	316.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	642.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,180.00	2,999.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	179,718.00	11,018.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,981.00	802.00	FEE SCHEDULE LAB	334,304.00	25,022.00
EKG/ECG	21,650.00	0.00	MRI SERVICES	32,305.00	0.00
IV THERAPY	112,079.00	5,031.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,005.00	2,619.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,084.00	13,570.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,218.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,110.00	730.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,401.33	1,627.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,229.56	10,685.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,886.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	461.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	648.00	666.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,823.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	155.00	24.60
OTHER IMAGING SERVICE	10,959.00	92.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,052.00	657.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,168.00	4,000.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,899.00	907.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	465.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,384.00	3,496.00			

TOTAL ANCILLARY	1,250,446.48	87,762.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,250,446.48	87,762.81

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2218081004502	03/18/18 - 03/18/18	03/26/18	0.00	24.60	0.00	0.00	0.00
8004	9818124000015	04/19/18 - 04/19/18	05/14/18	155.00	0.00	0.00	0.00	0.00
TOTAL				155.00	24.60	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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,729.59	ADJUSTMENTS	0.00
COVERED CHARGES	1,673.13	CONTRACTUAL ALLOW	1,192.34
NON-COVERD CHARGES	56.46	TOTAL MEDICAID LIAB	480.79
		LESS: COB	479.77
		LESS: COPAYMENT	1.02
		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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	40.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235.00	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	1,204.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	208.00	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	26.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,673.13	56.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,673.13	56.46

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,880.97	ADJUSTMENTS	446.72
COVERED CHARGES	29,440.64	CONTRACTUAL ALLOW	26,576.50
NON-COVERD CHARGES	4,440.33	TOTAL MEDICAID LIAB	2,864.14
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	2,777.14
		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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.62	6.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	244.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,026.00	326.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,365.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,315.00	907.00
EKG/ECG	465.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	960.00	74.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	14,111.00	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	2,838.21	3,052.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,440.64	4,440.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,440.64	4,440.33

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,533,403.10	ADJUSTMENTS	46,290.17
COVERED CHARGES	2,327,613.75	CONTRACTUAL ALLOW	1,607,998.42
NON-COVERD CHARGES	205,789.35	TOTAL MEDICAID LIAB	719,615.33
		LESS: COB	16,585.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	703,029.50

TOTAL NUMBER OF ADMISSIONS 136

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	405	0	262,941.40	7,782.20
ROUTINE NURSERY	47	0	30,059.80	1,729.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	452	0	293,001.20	9,511.70
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	68	0	58,098.20	22,708.80
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	58,098.20	22,708.80
TOTAL ACCOMODATIONS	520	0	351,099.40	32,220.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	476,516.53	41,851.06	OTHER LAB	8,613.70	0.00
MED/SURG SUPPLY	236,770.95	14,827.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	428,608.30	16,440.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,340.40	2,816.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,037.30	43,050.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,137.58	2,280.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	25,631.60	357.40	MRI SERVICES	23,860.20	0.00
IV THERAPY	4,341.60	5,321.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	147,696.40	9,194.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,919.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	183,420.60	22,970.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,176.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,222.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,279.50	958.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,257.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,890.72	751.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,647.60	545.80	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	69,792.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,502.00	600.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,481.60	10,906.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,280.20	407.80			
AUDIOLOGY	10,853.00	0.00			
CARDIOLOGY	4,458.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,868.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,787.40	288.20			

TOTAL ANCILLARY	1,976,514.35	173,568.85
TOTAL ACCOMODATIONS	351,099.40	32,220.50
TOTAL CHARGES	2,327,613.75	205,789.35

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,526.23	ADJUSTMENTS	0.00
COVERED CHARGES	7,526.13	CONTRACTUAL ALLOW	-737.73
NON-COVERD CHARGES	5,000.10	TOTAL MEDICAID LIAB	8,263.86
		LESS: COB	8,263.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,318.00	0.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,318.00	0.80
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	1,318.00	0.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,102.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,635.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	146.90	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	4,999.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,923.20	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	399.40	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,208.13	4,999.30
TOTAL ACCOMODATIONS	1,318.00	0.80
TOTAL CHARGES	7,526.13	5,000.10

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,072,452.53	ADJUSTMENTS	77,117.56
COVERED CHARGES	1,890,823.84	CONTRACTUAL ALLOW	1,399,669.15
NON-COVERD CHARGES	181,628.69	TOTAL MEDICAID LIAB	491,154.69
		LESS: COB	342.74
		LESS: COPAYMENT	1,251.00
		REIMBURSEMENT	489,560.95
		ALL OTHER	442,750.45
		FEE SCHEDULE-LAB	46,799.18
		INJECTABLE DRUGS	11.32
		TOTAL NUMBER OF CLAIMS	1,393

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,099.72	2,004.14	OTHER LAB	22,298.37	0.00
MED/SURG SUPPLY	90,896.70	880.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	495.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	146,916.70	3,689.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	273,347.90	42,556.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,315.60	3,654.30	FEE SCHEDULE LAB	489,779.80	28,534.50
EKG/ECG	26,749.40	1,270.80	MRI SERVICES	193,217.70	2,557.40
IV THERAPY	7,415.60	3,783.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,928.02	35,678.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,771.90	4,377.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,761.80	2,914.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	277,722.20	26,875.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,881.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,002.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	443.00	1,026.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,679.10	775.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	15,560.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,279.20	7,537.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	718.00	808.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,551.70	9,622.14			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,797.64	2,280.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,418.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,270.66	308.00			

TOTAL ANCILLARY	1,890,823.84	181,628.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,890,823.84	181,628.69

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,960.14	ADJUSTMENTS	0.00
COVERED CHARGES	12,376.64	CONTRACTUAL ALLOW	3,403.31
NON-COVERD CHARGES	4,583.50	TOTAL MEDICAID LIAB	8,973.33
		LESS: COB	8,961.33
		LESS: COPAYMENT	12.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	575.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,839.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203.00	203.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,400.00	1,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,623.80	378.80
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	1,958.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,252.80	1,252.80	AMBULANCE	0.00	0.00
GI SERVICES	1,414.30	903.90	CAST ROOM	0.00	0.00
EMERGENCY ROOM	392.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	718.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,376.64	4,583.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,376.64	4,583.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	158,153.86	ADJUSTMENTS	150.00
COVERED CHARGES	148,744.23	CONTRACTUAL ALLOW	139,698.23
NON-COVERD CHARGES	9,409.63	TOTAL MEDICAID LIAB	9,046.00
		LESS: COB	0.00
		LESS: COPAYMENT	354.00
		REIMBURSEMENT	8,692.00
		TOTAL NUMBER OF CLAIMS	181

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,541.44	107.63	OTHER LAB	1,269.10	0.00
MED/SURG SUPPLY	3,395.00	94.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,904.00	1,121.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,147.30	1,526.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,886.80	2,972.70
EKG/ECG	1,905.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,128.40	316.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,186.40	3,271.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	191.63	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,831.30	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	906.36	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	301.30	0.00			

TOTAL ANCILLARY	148,744.23	9,409.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,744.23	9,409.63

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,286.99	ADJUSTMENTS	5,089.42
COVERED CHARGES	45,437.30	CONTRACTUAL ALLOW	35,252.46
NON-COVERD CHARGES	3,849.69	TOTAL MEDICAID LIAB	10,184.84
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	10,169.84

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,091.33	20.16	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,373.80	249.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,036.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,143.40	52.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	61.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,063.37	2,866.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,926.60	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	12,305.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	600.50			
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	301.30	0.00			

TOTAL ANCILLARY	45,437.30	3,849.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,437.30	3,849.69

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,538.71	ADJUSTMENTS	0.00
COVERED CHARGES	59,538.71	CONTRACTUAL ALLOW	25,807.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	33,731.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,731.22

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	22	0	10,670.00	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	10,670.00	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	10,670.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,956.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,167.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,423.01	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,469.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,627.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	685.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	485.00	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	4,012.80	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	4,214.00	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	10,412.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	477.40	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,561.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,376.00	0.00			

TOTAL ANCILLARY	48,868.71	0.00
TOTAL ACCOMODATIONS	10,670.00	0.00
TOTAL CHARGES	59,538.71	0.00

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	552,874.82	ADJUSTMENTS	74,007.86
COVERED CHARGES	538,557.42	CONTRACTUAL ALLOW	234,413.06
NON-COVERD CHARGES	14,317.40	TOTAL MEDICAID LIAB	304,144.36
		LESS: COB	551.60
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	303,274.76
		ALL OTHER	268,361.30
		FEE SCHEDULE-LAB	27,314.51
		INJECTABLE DRUGS	7,598.95

TOTAL NUMBER OF CLAIMS 682

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,862.05	1,010.00	OTHER LAB	27,693.72	0.00
MED/SURG SUPPLY	14,209.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,502.85	506.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,129.30	805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,323.65	0.00	FEE SCHEDULE LAB	185,616.20	2,695.20
EKG/ECG	13,745.00	235.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,502.00	44.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	86.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,588.90	507.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,195.08	610.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,856.66	7,485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	76.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	605.00	343.20			
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	3,254.46	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,387.20	0.00			

TOTAL ANCILLARY	538,557.42	14,317.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	538,557.42	14,317.40

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,026.05	ADJUSTMENTS	0.00
COVERED CHARGES	2,888.45	CONTRACTUAL ALLOW	902.46
NON-COVERD CHARGES	137.60	TOTAL MEDICAID LIAB	1,985.99
		LESS: COB	1,985.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	297.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.05	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	699.85	27.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	298.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34.10	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	324.50	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	281.25	110.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	871.20	0.00			

TOTAL ANCILLARY	2,888.45	137.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,888.45	137.60

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,752.52	ADJUSTMENTS	97.00
COVERED CHARGES	41,996.32	CONTRACTUAL ALLOW	37,846.32
NON-COVERD CHARGES	756.20	TOTAL MEDICAID LIAB	4,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	3,979.00
		TOTAL NUMBER OF CLAIMS	83

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206.50	195.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	416.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,872.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,781.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,412.85	281.20
EKG/ECG	750.00	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	138.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,056.50	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	1,362.45	280.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,996.32	756.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,996.32	756.20

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,872.00	ADJUSTMENTS	0.00
COVERED CHARGES	178,657.00	CONTRACTUAL ALLOW	93,313.53
NON-COVERD CHARGES	6,215.00	TOTAL MEDICAID LIAB	85,343.47
		LESS: COB	1,156.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	84,187.41

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	32,358.00	5,514.00
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	50	0	32,358.00	5,514.00
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	50	0	32,358.00	5,514.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,748.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,103.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,556.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,098.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,198.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,146.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,926.00	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	19,197.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,309.00	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	2,204.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	866.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,444.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	701.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	146,299.00	701.00
TOTAL ACCOMODATIONS	32,358.00	5,514.00
TOTAL CHARGES	178,657.00	6,215.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,242,668.63	ADJUSTMENTS	50,112.27
COVERED CHARGES	1,198,040.60	CONTRACTUAL ALLOW	887,684.04
NON-COVERD CHARGES	44,628.03	TOTAL MEDICAID LIAB	310,356.56
		LESS: COB	1,393.13
		LESS: COPAYMENT	927.00
		REIMBURSEMENT	308,036.43
		ALL OTHER	267,739.00
		FEE SCHEDULE-LAB	38,280.81
		INJECTABLE DRUGS	2,016.62

TOTAL NUMBER OF CLAIMS 1,396

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,253.20	30.00	OTHER LAB	3,226.00	0.00
MED/SURG SUPPLY	12,420.00	627.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,708.00	1,952.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	192,527.00	17,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,012.00	3,752.03	FEE SCHEDULE LAB	334,685.00	7,837.00
EKG/ECG	9,064.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,467.00	136.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,849.00	1,306.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	311,342.00	3,936.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,537.40	726.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,749.00	5,167.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	152.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	924.00	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	NO CC/INVALID REV CODE	69.00	0.00
OTHER IMAGING SERVICE	17,392.00	168.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,820.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,920.00	435.00			

TOTAL ANCILLARY	1,198,040.60	44,628.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,198,040.60	44,628.03

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 10/01/17 THROUGH 09/30/18
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	2018277118679	09/27/18 - 09/27/18	10/08/18	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,081.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,863.00	CONTRACTUAL ALLOW	-1,208.82
NON-COVERD CHARGES	3,218.00	TOTAL MEDICAID LIAB	5,071.82
		LESS: COB	5,071.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	110.00	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	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,949.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	264.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,380.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,863.00	3,218.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,863.00	3,218.00

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

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,087.00	ADJUSTMENTS	1,707.00
COVERED CHARGES	40,515.00	CONTRACTUAL ALLOW	35,845.00
NON-COVERD CHARGES	3,572.00	TOTAL MEDICAID LIAB	4,670.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	4,568.00
		TOTAL NUMBER OF CLAIMS	83

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	433.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	268.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,088.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,218.00	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,334.00	334.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	101.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,153.00	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	932.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	722.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,515.00	3,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,515.00	3,572.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,776.00	ADJUSTMENTS	0.00
COVERED CHARGES	91,776.00	CONTRACTUAL ALLOW	77,187.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	14,579.67

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,757.00	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	4,019.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	91,776.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,776.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	278,684.75	ADJUSTMENTS	0.00
COVERED CHARGES	275,738.75	CONTRACTUAL ALLOW	167,982.83
NON-COVERD CHARGES	2,946.00	TOTAL MEDICAID LIAB	107,755.92
		LESS: COB	2,442.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	105,312.94

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	54	0	31,104.00	1,296.00
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	54	0	31,104.00	1,296.00
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	54	0	31,104.00	1,296.00

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,976.45	0.00	OTHER LAB	677.73	0.00
MED/SURG SUPPLY	12,647.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,603.50	0.00	EDUCATION & TRAINING	302.76	0.00
RADIOLOGY-DIAGNOSTIC	9,966.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,752.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,275.00	0.00	MRI SERVICES	1,326.51	0.00
IV THERAPY	10,986.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,812.77	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,499.59	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	17,391.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	256.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,014.56	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,752.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,047.12	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	1,120.00	0.00			

TOTAL ANCILLARY	244,634.75	1,650.00
TOTAL ACCOMODATIONS	31,104.00	1,296.00
TOTAL CHARGES	275,738.75	2,946.00

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,362,700.10	ADJUSTMENTS	45,175.16
COVERED CHARGES	1,188,877.87	CONTRACTUAL ALLOW	878,390.21
NON-COVERD CHARGES	173,822.23	TOTAL MEDICAID LIAB	310,487.66
		LESS: COB	1,460.59
		LESS: COPAYMENT	540.00
		REIMBURSEMENT	308,487.07
		ALL OTHER	282,088.94
		FEE SCHEDULE-LAB	21,071.25
		INJECTABLE DRUGS	5,326.88

TOTAL NUMBER OF CLAIMS 812

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,073.10	1,791.00	OTHER LAB	13,876.38	0.00
MED/SURG SUPPLY	17,680.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	579.45
RADIOLOGY-DIAGNOSTIC	74,153.23	6,164.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	100,742.85	37,865.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	143,482.25	25,591.10
EKG/ECG	23,625.36	2,025.00	MRI SERVICES	25,660.44	3,544.65
IV THERAPY	95,421.25	32,418.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,895.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,063.02	38,410.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,527.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,205.97	3,586.97	CAST ROOM	0.00	0.00
EMERGENCY ROOM	467,150.89	4,229.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,627.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,906.93	3,864.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,537.36	4,049.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	105.25
OTHER IMAGING SERVICE	39,096.69	1,550.31			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,876.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,745.20	2,698.08			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,529.63	3,697.59			

TOTAL ANCILLARY	1,188,877.87	173,822.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,188,877.87	173,822.23

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
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
4109	2218121000256	06/24/17 - 06/24/17	05/07/18	0.00	105.25	0.00	0.00	0.00
TOTAL				0.00	105.25	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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	122,340.25	ADJUSTMENTS	108.88
COVERED CHARGES	116,217.38	CONTRACTUAL ALLOW	110,735.26
NON-COVERD CHARGES	6,122.87	TOTAL MEDICAID LIAB	5,482.12
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	5,305.12
		TOTAL NUMBER OF CLAIMS	98

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,252.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	828.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,460.00	808.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,199.79	1,418.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,578.50	1,336.75
EKG/ECG	1,350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,294.55	159.51	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,430.56	450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,893.46	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	2,484.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	507.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	938.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	300.00			

TOTAL ANCILLARY	116,217.38	6,122.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	116,217.38	6,122.87

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	587,252.72	ADJUSTMENTS	0.00
COVERED CHARGES	570,729.72	CONTRACTUAL ALLOW	339,826.06
NON-COVERD CHARGES	16,523.00	TOTAL MEDICAID LIAB	230,903.66
		LESS: COB	9,501.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	221,402.63

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	80	0	79,474.00	16,523.00
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	79,474.00	16,523.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	15	0	30,165.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	30,165.00	0.00
TOTAL ACCOMODATIONS	95	0	109,639.00	16,523.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,837.09	0.00	OTHER LAB	2,030.00	0.00
MED/SURG SUPPLY	44,736.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	119,040.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,304.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,633.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	459.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,178.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,762.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,355.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,997.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,508.00	0.00	INJECTABLE DRUGS	67,416.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,576.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,215.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,608.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,516.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,909.00	0.00			

TOTAL ANCILLARY	461,090.72	0.00
TOTAL ACCOMODATIONS	109,639.00	16,523.00
TOTAL CHARGES	570,729.72	16,523.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,706,665.79	ADJUSTMENTS	72,309.73
COVERED CHARGES	2,504,635.68	CONTRACTUAL ALLOW	1,987,274.07
NON-COVERD CHARGES	202,030.11	TOTAL MEDICAID LIAB	517,361.61
		LESS: COB	473.40
		LESS: COPAYMENT	1,056.00
		REIMBURSEMENT	515,832.21
		ALL OTHER	460,158.39
		FEE SCHEDULE-LAB	52,310.75
		INJECTABLE DRUGS	3,363.07

TOTAL NUMBER OF CLAIMS 1,057

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,566.68	0.00	OTHER LAB	5,424.00	0.00
MED/SURG SUPPLY	281,187.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,260.00	2,749.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	349,652.00	56,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,973.00	4,120.02	FEE SCHEDULE LAB	533,571.94	32,101.11
EKG/ECG	30,163.00	3,383.00	MRI SERVICES	68,514.00	7,710.00
IV THERAPY	5,079.00	2,988.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	432,194.00	37,716.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,837.52	7,151.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	371,009.00	9,990.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	136,584.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	51,668.29	15,862.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,896.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	352.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,374.00
OTHER IMAGING SERVICE	40,807.00	1,574.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,152.00	1,788.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,641.00	8,622.00			

TOTAL ANCILLARY	2,504,635.68	202,030.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,504,635.68	202,030.11

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 01/01/18 THROUGH 12/31/18
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	2018177038984	06/20/18 - 06/20/18	07/02/18	0.00	3,687.00	0.00	0.00	0.00
615	2018177038984	06/20/18 - 06/20/18	07/02/18	0.00	3,687.00	0.00	0.00	0.00
TOTAL				0.00	7,374.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,066.63	ADJUSTMENTS	0.00
COVERED CHARGES	4,714.13	CONTRACTUAL ALLOW	298.67
NON-COVERD CHARGES	3,352.50	TOTAL MEDICAID LIAB	4,415.46
		LESS: COB	4,407.46
		LESS: COPAYMENT	8.00
		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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,741.00	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	3,328.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	201.00	24.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,714.13	3,352.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,714.13	3,352.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,831.66	ADJUSTMENTS	1,682.00
COVERED CHARGES	78,781.66	CONTRACTUAL ALLOW	75,021.66
NON-COVERD CHARGES	4,050.00	TOTAL MEDICAID LIAB	3,760.00
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	3,637.00
		TOTAL NUMBER OF CLAIMS	64

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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,466.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,983.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,232.00	256.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,175.00	2,415.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	470.00	292.00	FEE SCHEDULE LAB	16,083.35	1,071.00
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	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	40,256.00	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	1,702.61	16.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	78,781.66	4,050.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,781.66	4,050.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,225,981.20	ADJUSTMENTS	249,226.78
COVERED CHARGES	21,910,733.20	CONTRACTUAL ALLOW	15,435,162.50
NON-COVERD CHARGES	315,248.00	TOTAL MEDICAID LIAB	6,475,570.70
		LESS: COB	71,435.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,404,134.99

TOTAL NUMBER OF ADMISSIONS 574

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,611	0	2,741,550.00	92,937.00
ROUTINE NURSERY	172	0	120,540.00	43,750.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,783	0	2,862,090.00	136,687.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	818	0	2,149,169.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	818	0	2,149,169.00	0.00
TOTAL ACCOMODATIONS	3,601	0	5,011,259.00	136,687.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,598,913.74	0.00	OTHER LAB	81,749.00	0.00
MED/SURG SUPPLY	395,507.29	2,490.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,471,209.92	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	709,853.00	0.00	OTHER THERAPEUTIC SVC	0.00	69,216.00
CT SCAN	1,106,584.00	27,301.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	232,977.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	67,349.00	0.00	MRI SERVICES	320,085.00	0.00
IV THERAPY	518,839.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,422,718.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	201,016.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,174,715.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	432,568.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	131,966.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	786,847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	283,161.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	114,193.00	0.00	INJECTABLE DRUGS	2,352,318.94	0.00
RADIOLOGY THERAPEUTIC	138,395.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	91,678.76	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	104,267.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	125,477.00	7,047.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	199,590.00	0.00
LITHOTRIPSY	36,730.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	119,948.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	289,651.00	23,342.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	85,532.00	49,165.00			
AUDIOLOGY	476.00	0.00			
CARDIOLOGY	165,497.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,776.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,886.00	0.00			

TOTAL ANCILLARY	16,899,474.20	178,561.00
TOTAL ACCOMODATIONS	5,011,259.00	136,687.00
TOTAL CHARGES	21,910,733.20	315,248.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,297.00	ADJUSTMENTS	0.00
COVERED CHARGES	154,842.00	CONTRACTUAL ALLOW	68,733.53
NON-COVERD CHARGES	5,455.00	TOTAL MEDICAID LIAB	86,108.47
		LESS: COB	86,108.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	25	0	26,250.00	800.00
ROUTINE NURSERY	10	0	9,135.00	4,655.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	35	0	35,385.00	5,455.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	7,060.00	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	2	0	7,060.00	0.00
TOTAL ACCOMODATIONS	37	0	42,445.00	5,455.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	910.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,573.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,945.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,823.00	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	436.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,117.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,304.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,875.00	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	10,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	296.00	0.00	INJECTABLE DRUGS	8,929.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,397.00	0.00
TOTAL ACCOMODATIONS	42,445.00	5,455.00
TOTAL CHARGES	154,842.00	5,455.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,979,190.98	ADJUSTMENTS	533,227.57
COVERED CHARGES	21,588,368.24	CONTRACTUAL ALLOW	18,054,165.32
NON-COVERD CHARGES	1,390,822.74	TOTAL MEDICAID LIAB	3,534,202.92
		LESS: COB	9,571.69
		LESS: COPAYMENT	9,997.03
		REIMBURSEMENT	3,514,634.20
		ALL OTHER	3,280,968.85
		FEE SCHEDULE-LAB	233,072.14
		INJECTABLE DRUGS	593.21

TOTAL NUMBER OF CLAIMS 7,866

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,003,075.71	1,463.69	OTHER LAB	168,028.00	0.00
MED/SURG SUPPLY	194,764.22	624.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	995.20
RADIOLOGY-DIAGNOSTIC	690,188.00	55,487.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,077,884.00	266,377.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	63,048.00	17,463.07	FEE SCHEDULE LAB	1,940,320.15	80,622.32
EKG/ECG	95,864.00	920.00	MRI SERVICES	312,508.00	27,903.00
IV THERAPY	1,897,143.00	58,595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,749,576.35	262,900.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,472.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	745,130.00	16,574.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	528,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	61,539.00	19,389.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,482,505.00	12,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	449,466.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,878.48	840.00
RADIOLOGY THERAPEUTIC	2,575,086.00	86,015.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,116.00	3,737.19	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,460.00	4,891.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,285.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,400.00	83.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	279,711.00	87,157.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	650,352.00	51,515.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	142,704.00	66,843.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,918.00	218,479.00			
AUDIOLOGY	0.00	6,876.00			
CARDIOLOGY	23,654.00	7,733.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,322.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	350,907.33	24,179.00			

TOTAL ANCILLARY	21,588,368.24	1,390,822.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,588,368.24	1,390,822.74

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	511,983.75	ADJUSTMENTS	0.00
COVERED CHARGES	338,507.50	CONTRACTUAL ALLOW	165,530.14
NON-COVERD CHARGES	173,476.25	TOTAL MEDICAID LIAB	172,977.36
		LESS: COB	172,880.63
		LESS: COPAYMENT	96.73
		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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,465.26	0.00	OTHER LAB	1,474.00	0.00
MED/SURG SUPPLY	8,063.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,719.00	3,276.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,854.00	17,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,331.00	1,451.00
EKG/ECG	1,840.00	0.00	MRI SERVICES	0.00	2,339.00
IV THERAPY	29,333.00	1,175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,353.75	49,816.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	206.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,159.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,353.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,488.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,480.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,315.49	59,275.00
RADIOLOGY THERAPEUTIC	74,009.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	511.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	345.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	472.00	21,812.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,289.00	3,092.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,926.00	5,305.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	730.00	450.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	480.00			

TOTAL ANCILLARY	338,507.50	173,476.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338,507.50	173,476.25

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	589,121.58	ADJUSTMENTS	1,765.02
COVERED CHARGES	565,812.58	CONTRACTUAL ALLOW	542,821.24
NON-COVERD CHARGES	23,309.00	TOTAL MEDICAID LIAB	22,991.34
		LESS: COB	0.00
		LESS: COPAYMENT	834.00
		REIMBURSEMENT	22,157.34

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,361.58	0.00	OTHER LAB	5,855.00	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	62,481.00	6,042.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,733.00	9,369.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,686.00	2,634.00
EKG/ECG	4,232.00	0.00	MRI SERVICES	10,768.00	2,339.00
IV THERAPY	82,629.00	127.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	559.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,914.00	412.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	288,704.00	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	62.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,828.00	2,386.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	565,812.58	23,309.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	565,812.58	23,309.00

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 HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,342.56	ADJUSTMENTS	0.00
COVERED CHARGES	6,641.56	CONTRACTUAL ALLOW	5,839.72
NON-COVERD CHARGES	701.00	TOTAL MEDICAID LIAB	801.84
		LESS: COB	801.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,249.00	88.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	413.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,413.00	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	113.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	613.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	345.00	0.00			

TOTAL ANCILLARY	6,641.56	701.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,641.56	701.00

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,198,822.78	ADJUSTMENTS	33,208.38
COVERED CHARGES	3,163,112.16	CONTRACTUAL ALLOW	2,824,853.13
NON-COVERD CHARGES	35,710.62	TOTAL MEDICAID LIAB	338,259.03
		LESS: COB	0.00
		LESS: COPAYMENT	247.82
		REIMBURSEMENT	338,011.21

TOTAL NUMBER OF CLAIMS 61

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,755,211.06	4.72	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,982.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,966.00	4,162.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,266.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,974.00	340.00
EKG/ECG	184.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,484.00	2,891.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,477.10	26,300.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,605.00	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	12,940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	66,902.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	98,114.00	0.00
LITHOTRIPSY	36,730.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	858.00	1,667.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,419.00	345.00			

TOTAL ANCILLARY	3,163,112.16	35,710.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,163,112.16	35,710.62

GEORGIA DEPARTMENT OF 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,085,327.13	ADJUSTMENTS	563,906.65
COVERED CHARGES	46,619,114.47	CONTRACTUAL ALLOW	38,884,165.98
NON-COVERD CHARGES	466,212.66	TOTAL MEDICAID LIAB	7,734,948.49
		LESS: COB	60,184.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,674,764.39

TOTAL NUMBER OF ADMISSIONS 787

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,187	0	4,302,344.00	250,307.00
ROUTINE NURSERY	97	0	83,601.00	482.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,284	0	4,385,945.00	250,789.00
SPECIAL CARE SERVICES				
CCU	151	0	379,614.00	0.00
ICU	823	0	2,264,345.00	0.00
NICU	11	0	37,642.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	985	0	2,681,601.00	0.00
TOTAL ACCOMODATIONS	4,269	0	7,067,546.00	250,789.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,330,019.99	7,620.75	OTHER LAB	236,718.80	1,908.80
MED/SURG SUPPLY	3,319,836.38	7,378.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,457,848.60	1,728.70	EDUCATION & TRAINING	800.00	0.00
RADIOLOGY-DIAGNOSTIC	840,843.64	599.16	OTHER THERAPEUTIC SVC	0.00	342.00
CT SCAN	2,406,272.50	26,827.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	268,778.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	273,160.50	0.00	MRI SERVICES	500,473.50	4,823.80
IV THERAPY	234,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,545,751.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	200,834.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,298,586.60	2,558.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924,886.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	140,035.00	1,970.60	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,903,385.21	2,075.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	207,312.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	249,683.19	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	36,552.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	66,101.13	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	150,908.53	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	504,711.60	9,124.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,689.70	691.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	686,747.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	192,681.97	6,615.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	404,894.90	140,302.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	270,580.50	856.00			
AUDIOLOGY	1,511.20	0.00			
CARDIOLOGY	1,573,264.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,023.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,536.58	0.00			

TOTAL ANCILLARY	39,551,568.47	215,423.66
TOTAL ACCOMODATIONS	7,067,546.00	250,789.00
TOTAL CHARGES	46,619,114.47	466,212.66

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,059.98	ADJUSTMENTS	0.00
COVERED CHARGES	38,059.98	CONTRACTUAL ALLOW	11,752.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	26,307.51
		LESS: COB	26,307.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4	0	5,392.00	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	5,392.00	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	5,392.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,635.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	857.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,272.00	0.00	EDUCATION & TRAINING	160.00	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	8,532.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,624.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,868.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,909.00	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	1,110.00	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	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	859.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	730.00	0.00			

TOTAL ANCILLARY	32,667.98	0.00
TOTAL ACCOMODATIONS	5,392.00	0.00
TOTAL CHARGES	38,059.98	0.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,509,079.62	ADJUSTMENTS	465,355.13
COVERED CHARGES	22,633,109.30	CONTRACTUAL ALLOW	20,035,964.39
NON-COVERD CHARGES	1,875,970.32	TOTAL MEDICAID LIAB	2,597,144.91
		LESS: COB	3,036.26
		LESS: COPAYMENT	5,079.00
		REIMBURSEMENT	2,589,029.65
		ALL OTHER	2,320,740.10
		FEE SCHEDULE-LAB	208,384.92
		INJECTABLE DRUGS	59,904.63
		TOTAL NUMBER OF CLAIMS	5,325

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621,783.68	0.00	OTHER LAB	309,738.60	0.00
MED/SURG SUPPLY	927,777.08	1,090.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,158,368.40	34,220.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,660,794.50	492,070.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,669.30	35,910.85	FEE SCHEDULE LAB	3,465,759.72	94,230.38
EKG/ECG	393,363.50	2,150.00	MRI SERVICES	285,258.00	37,229.70
IV THERAPY	857,515.40	37,140.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,243,594.54	254,172.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	366,156.30	22,145.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	640,573.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	38,254.10	8,383.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,614,758.80	7,434.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,264.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,372.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	952,142.96	433,030.99
RADIOLOGY THERAPEUTIC	45,983.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	31,741.20	22,894.90	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,463.70	12,198.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,269.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,415.70	8,684.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,732.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	503,195.02	119,323.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	101,285.10	32,074.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	250,055.20	59,798.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	450,681.40	58,041.00			
AMBULATORY SURGERY	8,000.20	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	584,848.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	619,933.88	94,104.90			

TOTAL ANCILLARY	22,633,109.30	1,875,970.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,633,109.30	1,875,970.32

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,822.96	ADJUSTMENTS	0.00
COVERED CHARGES	92,393.95	CONTRACTUAL ALLOW	65,774.38
NON-COVERD CHARGES	11,429.01	TOTAL MEDICAID LIAB	26,619.57
		LESS: COB	26,612.00
		LESS: COPAYMENT	7.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,359.39	0.00	OTHER LAB	1,755.60	0.00
MED/SURG SUPPLY	3,379.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,814.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,466.70	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,198.62	1,295.17
EKG/ECG	409.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,980.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,841.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,704.10	445.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,069.00	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	929.94	160.14
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	805.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,005.40	3,178.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,318.40	1,496.00			

TOTAL ANCILLARY	92,393.95	11,429.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	92,393.95	11,429.01

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,316,523.96	ADJUSTMENTS	323.64
COVERED CHARGES	1,205,583.93	CONTRACTUAL ALLOW	1,174,649.11
NON-COVERD CHARGES	110,940.03	TOTAL MEDICAID LIAB	30,934.82
		LESS: COB	0.00
		LESS: COPAYMENT	1,107.00
		REIMBURSEMENT	29,827.82
		TOTAL NUMBER OF CLAIMS	553

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,236.89	0.00	OTHER LAB	20,651.60	0.00
MED/SURG SUPPLY	6,051.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,221.56	6,830.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,557.80	82,654.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	206,664.53	3,515.75
EKG/ECG	20,681.00	0.00	MRI SERVICES	3,791.00	5,294.40
IV THERAPY	48,500.30	901.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,248.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	646,606.40	518.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39,029.62	2,184.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,862.10	9,040.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,370.80	0.00			

TOTAL ANCILLARY	1,205,583.93	110,940.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,205,583.93	110,940.03

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,831.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,083.20	CONTRACTUAL ALLOW	5,390.62
NON-COVERD CHARGES	2,748.30	TOTAL MEDICAID LIAB	1,692.58
		LESS: COB	1,692.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.00	0.00	OTHER LAB	1,755.60	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	669.00	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	1,855.00	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	2,465.90	919.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,002.70	1,159.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,083.20	2,748.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,083.20	2,748.30

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,355,330.30	ADJUSTMENTS	10,875.20
COVERED CHARGES	1,298,043.29	CONTRACTUAL ALLOW	1,167,468.89
NON-COVERD CHARGES	57,287.01	TOTAL MEDICAID LIAB	130,574.40
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	130,445.40

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,962.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	227,487.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,348.07	11,057.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,426.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,209.19	126.47
EKG/ECG	2,457.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,196.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	440,881.43	12,104.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,154.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,546.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,989.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100,923.49	33,696.07
RADIOLOGY THERAPEUTIC	7,284.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	302.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	114,508.67	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	153,273.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,346.80	0.00			

TOTAL ANCILLARY	1,298,043.29	57,287.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,298,043.29	57,287.01

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	326,209,456.27	ADJUSTMENTS	36,452,534.01
COVERED CHARGES	319,781,868.22	CONTRACTUAL ALLOW	225,328,043.75
NON-COVERD CHARGES	6,427,588.05	TOTAL MEDICAID LIAB	94,453,824.47
		LESS: COB	472,843.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	93,980,980.70

TOTAL NUMBER OF ADMISSIONS 2,806

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15,588	0	24,439,552.75	3,398,175.75
ROUTINE NURSERY	1,908	0	9,539,694.00	14,060.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17,496	0	33,979,246.75	3,412,236.25
SPECIAL CARE SERVICES				
CCU	2,839	0	13,334,326.50	0.00
ICU	0	0	0.00	0.00
NICU	341	0	2,317,024.00	0.00
PED ICU	4,193	0	19,483,424.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,373	0	35,134,774.50	0.00
TOTAL ACCOMODATIONS	24,869	0	69,114,021.25	3,412,236.25

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,660,778.60	193,919.75	OTHER LAB	1,174,592.00	0.00
MED/SURG SUPPLY	17,309,423.00	285,381.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,653,467.60	860,846.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,950,780.50	4,827.00	OTHER THERAPEUTIC SVC	58,381.50	169,119.50
CT SCAN	1,868,708.00	90,129.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,530,448.00	7,504.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	446,709.50	350.50	MRI SERVICES	1,714,278.50	0.00
IV THERAPY	41,829.00	6,281.50	PROFESSIONAL FEES	0.00	4,635.00
OPERATING ROOM	38,748,697.00	51,512.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,001,303.91	232,609.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,017,954.00	26,991.00	AMBULANCE	0.00	0.00
GI SERVICES	14,441.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,594,031.36	34,674.64	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	979,017.50	1,333.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,013,399.18	0.00	INJECTABLE DRUGS	12,350.00	0.00
RADIOLOGY THERAPEUTIC	218,608.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,110,447.00	3,584.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	679,702.00	3,961.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	122,551.00	194,198.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,117.00	47,386.00	TRAUMA RESPONSE	0.00	67,976.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,407,081.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	921,326.50	129,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,907,248.00	186,126.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,378.50	8,417.00			
AUDIOLOGY	40,884.00	111.00			
CARDIOLOGY	6,883,230.50	7,747.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,674,329.00	5,774.00			
ORGAN ACQUISITION	4,386,781.50	16,351.00			
TREATMENT/OBSERV. RM	393,572.50	374,170.00			

TOTAL ANCILLARY	250,667,846.97	3,015,351.80
TOTAL ACCOMODATIONS	69,114,021.25	3,412,236.25
TOTAL CHARGES	319,781,868.22	6,427,588.05

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,460,698.65	ADJUSTMENTS	0.00
COVERED CHARGES	5,406,551.65	CONTRACTUAL ALLOW	2,805,066.04
NON-COVERD CHARGES	54,147.00	TOTAL MEDICAID LIAB	2,601,485.61
		LESS: COB	2,601,485.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	177	0	280,231.00	44,103.50
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	177	0	280,231.00	44,103.50
SPECIAL CARE SERVICES				
CCU	101	0	470,740.50	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	28	0	132,756.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	129	0	603,496.50	0.00
TOTAL ACCOMODATIONS	306	0	883,727.50	44,103.50

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	601,919.75	0.00	OTHER LAB	14,961.00	0.00
MED/SURG SUPPLY	407,833.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	745,969.07	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	81,371.50	0.00	OTHER THERAPEUTIC SVC	0.00	2,612.00
CT SCAN	13,012.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,035.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,570.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.50	0.00	PROFESSIONAL FEES	0.00	7,240.50
OPERATING ROOM	1,050,451.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	369,784.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	340,970.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,426.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,581.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	24,897.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,505.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,894.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,855.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	417,204.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,842.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,614.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	229.50	0.00			
CARDIOLOGY	113,699.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,296.00	0.00			
ORGAN ACQUISITION	142,640.50	0.00			
TREATMENT/OBSERV. RM	2,867.50	0.00			

TOTAL ANCILLARY	4,522,824.15	10,043.50
TOTAL ACCOMODATIONS	883,727.50	44,103.50
TOTAL CHARGES	5,406,551.65	54,147.00

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,308,323.43	ADJUSTMENTS	4,894,899.21
COVERED CHARGES	72,283,233.77	CONTRACTUAL ALLOW	56,269,830.91
NON-COVERD CHARGES	8,025,089.66	TOTAL MEDICAID LIAB	16,013,402.86
		LESS: COB	29,439.24
		LESS: COPAYMENT	190.67
		REIMBURSEMENT	15,983,772.95
		ALL OTHER	12,185,258.90
		FEE SCHEDULE-LAB	853,691.15
		INJECTABLE DRUGS	2,944,822.90

TOTAL NUMBER OF CLAIMS 18,656

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,606,843.00	9,543.50
MED/SURG SUPPLY	4,057,446.26	2,221.06
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,602,126.50	46,952.00
CT SCAN	1,703,035.50	103,310.50
PHYSICAL THERAPY	21,440.50	34,524.50
EKG/ECG	141,863.50	11,324.50
IV THERAPY	1,480,508.50	42,675.00
OPERATING ROOM	9,161,139.25	842,280.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	923,821.87	99,936.17
ANESTHESIA	5,182,396.50	0.00
GI SERVICES	7,851.50	0.00
EMERGENCY ROOM	6,196,163.50	68,753.00
RECOVERY ROOM	1,499,229.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	431,178.00	6,720.00
OCCUPATIONAL THERAPY	5,768.00	10,655.00
SPEECH PATHOLOGY	439,856.50	28,396.50
RENAL DIALYSIS	0.00	2,663.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,183,570.50	242,264.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	957,295.00	152,194.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,157,437.00	5,065.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	345,933.00	48,102.56
AUDIOLOGY	151,037.00	3,811.50
CARDIOLOGY	1,578,150.00	514,440.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,945,812.50	1,579.50
ORGAN ACQUISITION	0.00	31,053.00
TREATMENT/OBSERV. RM	1,702,425.50	866,217.50
OTHER LAB	771,437.50	6,154.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	9,156.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,217,353.10	2,461,012.92
MRI SERVICES	3,826,823.50	306,477.50
PROFESSIONAL FEES	0.00	2,533.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,669,646.70	1,878,643.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	105,441.00
IMPL DEV CHARGE PATIENTS	315,644.59	80,988.70
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	72,283,233.77	8,025,089.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,283,233.77	8,025,089.66

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
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	5918163000137	05/11/18 - 05/12/18	06/18/18	0.00	0.00	0.00	0.00	0.00
-1	5918163000137	05/11/18 - 05/12/18	06/18/18	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,145,518.63	ADJUSTMENTS	0.00
COVERED CHARGES	2,359,588.90	CONTRACTUAL ALLOW	671,649.93
NON-COVERD CHARGES	785,929.73	TOTAL MEDICAID LIAB	1,687,938.97
		LESS: COB	1,687,926.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 474

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,722.50	300.00	OTHER LAB	16,601.50	628.00
MED/SURG SUPPLY	193,887.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,500.00	2,560.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,312.50	44,371.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,032.00	1,920.00	FEE SCHEDULE LAB	409,263.87	64,998.50
EKG/ECG	3,735.00	701.00	MRI SERVICES	144,940.00	97,042.50
IV THERAPY	4,704.50	391.50	PROFESSIONAL FEES	0.00	1,118.00
OPERATING ROOM	395,596.00	191,958.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,951.52	3,077.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	353,236.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,439.50	4,499.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	176,269.25	89,536.00
RADIOLOGY THERAPEUTIC	79,545.50	640.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,920.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,331.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,415.50	10,239.00	TRAUMA RESPONSE	0.00	2,576.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,617.73	81,472.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,397.50	16,511.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,947.50	14,685.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,722.00	382.00			
AUDIOLOGY	2,594.50	331.50			
CARDIOLOGY	47,746.00	130,691.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,275.50	0.00			
ORGAN ACQUISITION	0.00	8,931.00			
TREATMENT/OBSERV. RM	45,885.50	15,035.00			

TOTAL ANCILLARY	2,359,588.90	785,929.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,359,588.90	785,929.73

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,051,390.22	ADJUSTMENTS	20,180.75
COVERED CHARGES	997,173.47	CONTRACTUAL ALLOW	943,570.84
NON-COVERD CHARGES	54,216.75	TOTAL MEDICAID LIAB	53,602.63
		LESS: COB	6.26
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	53,590.37

TOTAL NUMBER OF CLAIMS 866

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,171.50	0.00	OTHER LAB	4,159.00	0.00
MED/SURG SUPPLY	25,306.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,253.00	7,567.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,078.50	4,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	181,192.94	30,844.50
EKG/ECG	4,206.00	0.00	MRI SERVICES	2,509.50	2,584.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	297.00
OPERATING ROOM	1,835.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	766.00	396.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,180.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	639,771.50	2,887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,357.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,709.50	2,783.25
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	1,184.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,749.50	1,387.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,301.00	1,281.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,442.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	997,173.47	54,216.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	997,173.47	54,216.75

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,510.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,092.50	CONTRACTUAL ALLOW	9,321.69
NON-COVERD CHARGES	1,417.50	TOTAL MEDICAID LIAB	9,770.81
		LESS: COB	9,770.81
		LESS: COPAYMENT	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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	257.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,539.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,319.00	0.00
EKG/ECG	701.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	559.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,685.50	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	172.50	165.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,387.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,092.50	1,417.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,092.50	1,417.50

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 AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,948,253.18	ADJUSTMENTS	570,177.40
COVERED CHARGES	19,885,087.59	CONTRACTUAL ALLOW	16,479,173.58
NON-COVERD CHARGES	3,063,165.59	TOTAL MEDICAID LIAB	3,405,914.01
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	3,405,908.01

TOTAL NUMBER OF CLAIMS 380

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,040.25	0.00	OTHER LAB	2,894.00	0.00
MED/SURG SUPPLY	3,100,754.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335,820.50	292,833.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,951.00	3,419.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,144.00	FEE SCHEDULE LAB	932,307.66	291,410.50
EKG/ECG	3,735.00	14,249.50	MRI SERVICES	52,199.00	33,262.00
IV THERAPY	215,465.00	2,765.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,146,269.00	853,433.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,766.43	11,304.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,328,269.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,360.00	1,010.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	257,187.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,368,591.00	95,833.75
RADIOLOGY THERAPEUTIC	25,619.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,192.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,331.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,092.00	5,702.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,303,552.74	225,063.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,727.00	9,830.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,495.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,014.00	455.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,272,047.50	1,126,348.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,395.50	0.00			
ORGAN ACQUISITION	0.00	8,931.00			
TREATMENT/OBSERV. RM	221,534.00	77,645.50			

TOTAL ANCILLARY	19,885,087.59	3,063,165.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,885,087.59	3,063,165.59

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	729,634.33	ADJUSTMENTS	0.00
COVERED CHARGES	637,596.08	CONTRACTUAL ALLOW	28,112.45
NON-COVERD CHARGES	92,038.25	TOTAL MEDICAID LIAB	609,483.63
		LESS: COB	609,483.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,013.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49,291.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,665.00	35,966.50	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	28,121.00	9,532.50
EKG/ECG	0.00	701.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	804.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,263.50	19,961.50	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	31,269.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,220.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,292.25	7,794.75
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	3,387.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500.00	2,392.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,572.00	14,886.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	637,596.08	92,038.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	637,596.08	92,038.25

** END OF REPORT **

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,927,255.38	ADJUSTMENTS	723,740.81
COVERED CHARGES	52,542,469.38	CONTRACTUAL ALLOW	45,670,456.11
NON-COVERD CHARGES	384,786.00	TOTAL MEDICAID LIAB	6,872,013.27
		LESS: COB	7,839.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,864,173.29

TOTAL NUMBER OF ADMISSIONS 739

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,974	0	3,614,340.00	216,195.00
ROUTINE NURSERY	136	0	252,875.00	20,660.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,110	0	3,867,215.00	236,855.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,424	0	4,971,080.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,424	0	4,971,080.00	0.00
TOTAL ACCOMODATIONS	3,534	0	8,838,295.00	236,855.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,325,646.83	0.00	OTHER LAB	266,502.00	0.00
MED/SURG SUPPLY	1,351,596.25	3,051.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,810,621.00	840.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938,932.25	0.00	OTHER THERAPEUTIC SVC	0.00	4,203.00
CT SCAN	3,670,004.00	35,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	656,266.35	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	726,933.00	0.00	MRI SERVICES	790,716.00	0.00
IV THERAPY	103,173.00	791.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,883,413.00	14,462.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	466,388.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,270,609.40	3,648.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,210,157.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	182,491.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,796,856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	331,113.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	360,329.00	0.00	INJECTABLE DRUGS	6,228,254.81	0.00
RADIOLOGY THERAPEUTIC	68,101.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	571,497.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	123,833.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	179,959.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,038.00	338.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	378,575.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	261,034.00	30,360.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	134,595.00	43,417.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	401,216.00	0.00			
AUDIOLOGY	0.00	11,016.00			
CARDIOLOGY	3,120,369.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,564.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	76,390.00	0.00			

TOTAL ANCILLARY	43,704,174.38	147,931.00
TOTAL ACCOMODATIONS	8,838,295.00	236,855.00
TOTAL CHARGES	52,542,469.38	384,786.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	178,560.51	ADJUSTMENTS	0.00
COVERED CHARGES	175,897.51	CONTRACTUAL ALLOW	135,010.02
NON-COVERD CHARGES	2,663.00	TOTAL MEDICAID LIAB	40,887.49
		LESS: COB	40,887.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	16	0	29,460.00	1,630.00
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	29,460.00	1,630.00
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	29,460.00	1,630.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,324.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,911.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,817.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	587.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,133.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,185.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,846.00	0.00	MRI SERVICES	5,899.00	0.00
IV THERAPY	348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,853.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,593.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,251.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,366.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,490.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,356.00	0.00	INJECTABLE DRUGS	11,780.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,186.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,244.00	1,033.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	146,437.51	1,033.00
TOTAL ACCOMODATIONS	29,460.00	1,630.00
TOTAL CHARGES	175,897.51	2,663.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,690,423.68	ADJUSTMENTS	166,274.01
COVERED CHARGES	27,213,381.72	CONTRACTUAL ALLOW	25,528,028.28
NON-COVERD CHARGES	3,477,041.96	TOTAL MEDICAID LIAB	1,685,353.44
		LESS: COB	1,861.14
		LESS: COPAYMENT	3,141.00
		REIMBURSEMENT	1,680,351.30
		ALL OTHER	1,461,203.72
		FEE SCHEDULE-LAB	182,332.56
		INJECTABLE DRUGS	36,815.02

TOTAL NUMBER OF CLAIMS 4,267

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	474,088.31	188,011.47	OTHER LAB	195,194.00	0.00
MED/SURG SUPPLY	466,784.75	47,293.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,233,616.25	246,028.00	OTHER THERAPEUTIC SVC	0.00	280.00
CT SCAN	4,624,468.00	676,902.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	30,310.00	FEE SCHEDULE LAB	6,469,653.00	597,903.00
EKG/ECG	819,700.00	3,692.00	MRI SERVICES	323,621.00	65,604.00
IV THERAPY	619,996.00	50,332.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,606,104.21	365,469.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,815.00	1,225.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,490.00	402.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	247,667.50	91,310.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,148,046.00	40,002.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	393,015.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	421,814.50	343,081.20
RADIOLOGY THERAPEUTIC	514,692.00	216,020.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	29,221.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,487.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,404.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,535.00	6,321.00	TRAUMA RESPONSE	0.00	9,500.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	138,725.00	20,123.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	693,337.00	85,600.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,646.00	6,198.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	511,705.00	125,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	685,837.00	191,174.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,396.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	362,048.20	32,968.00			

TOTAL ANCILLARY	27,213,381.72	3,477,041.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,213,381.72	3,477,041.96

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	317,672.75	ADJUSTMENTS	0.00
COVERED CHARGES	217,919.50	CONTRACTUAL ALLOW	159,231.30
NON-COVERD CHARGES	99,753.25	TOTAL MEDICAID LIAB	58,688.20
		LESS: COB	58,613.14
		LESS: COPAYMENT	75.06
		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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,377.75	2,428.75	OTHER LAB	1,522.00	0.00
MED/SURG SUPPLY	9,204.25	167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,168.00	4,499.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,271.00	27,946.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,330.00	2,627.00
EKG/ECG	7,384.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,408.00	209.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,614.00	45,589.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	886.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,131.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,015.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,311.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	687.50	645.50
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	1,058.00	240.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,813.00	1,633.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	13,769.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,115.00	0.00			

TOTAL ANCILLARY	217,919.50	99,753.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,919.50	99,753.25

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,923,474.00	ADJUSTMENTS	6,245.91
COVERED CHARGES	1,740,803.25	CONTRACTUAL ALLOW	1,714,634.29
NON-COVERD CHARGES	182,670.75	TOTAL MEDICAID LIAB	26,168.96
		LESS: COB	0.00
		LESS: COPAYMENT	837.00
		REIMBURSEMENT	25,331.96
		TOTAL NUMBER OF CLAIMS	445

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,408.75	15,807.50	OTHER LAB	7,376.00	0.00
MED/SURG SUPPLY	3,500.00	166.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,134.50	19,824.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	301,630.00	83,145.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	526,463.00	14,739.00
EKG/ECG	41,535.00	0.00	MRI SERVICES	8,739.00	5,899.00
IV THERAPY	41,819.00	2,090.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	936.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	646,513.00	2,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,544.00	17,621.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,469.00	17,351.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,016.00	1,033.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,463.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	1,740,803.25	182,670.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,740,803.25	182,670.75

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,046.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,896.00	CONTRACTUAL ALLOW	13,068.81
NON-COVERD CHARGES	1,150.00	TOTAL MEDICAID LIAB	6,827.19
		LESS: COB	6,821.19
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	667.00	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	781.00	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	9,410.00	1,035.00
EKG/ECG	1,846.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	419.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,773.00	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	115.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,896.00	1,150.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,896.00	1,150.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	999,600.25	ADJUSTMENTS	0.00
COVERED CHARGES	881,761.25	CONTRACTUAL ALLOW	832,795.85
NON-COVERD CHARGES	117,839.00	TOTAL MEDICAID LIAB	48,965.40
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	48,926.40

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,724.53	2,440.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56,685.00	8,193.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,913.00	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	24,494.00	377.00
EKG/ECG	10,153.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	264,845.75	91,937.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	429.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,115.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,369.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,307.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,225.25	725.75
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	64,601.00	6,876.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	288,601.00	7,290.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,298.72	0.00			

TOTAL ANCILLARY	881,761.25	117,839.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	881,761.25	117,839.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	187,793,713.35	ADJUSTMENTS	13,744,397.00
COVERED CHARGES	181,898,105.74	CONTRACTUAL ALLOW	127,091,149.03
NON-COVERD CHARGES	5,895,607.61	TOTAL MEDICAID LIAB	54,806,956.71
		LESS: COB	614,548.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	54,192,408.45

TOTAL NUMBER OF ADMISSIONS 2,679

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,971	0	18,915,529.00	4,648,961.00
ROUTINE NURSERY	1,361	0	5,803,790.50	40,506.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,332	0	24,719,319.50	4,689,467.50
SPECIAL CARE SERVICES				
CCU	7	0	32,203.50	0.00
ICU	0	0	0.00	0.00
NICU	426	0	2,891,772.00	0.00
PED ICU	4,840	0	22,556,096.00	23,002.50
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,273	0	25,480,071.50	23,002.50
TOTAL ACCOMODATIONS	18,605	0	50,199,391.00	4,712,470.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,270,128.50	62,980.50	OTHER LAB	375,536.00	3,615.00
MED/SURG SUPPLY	8,483,006.84	38,622.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,309,798.26	44,601.01	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,909,742.00	609.00	OTHER THERAPEUTIC SVC	32,735.50	160,485.00
CT SCAN	2,163,085.50	1,638.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	945,070.00	2,464.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	96,701.00	0.00	MRI SERVICES	1,769,709.50	0.00
IV THERAPY	91,800.50	3,578.50	PROFESSIONAL FEES	0.00	16,022.00
OPERATING ROOM	13,262,330.50	3,450.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,446,516.83	169,420.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,899,558.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,151.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,593,867.00	18,869.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	611,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,003,072.50	0.00	INJECTABLE DRUGS	1,235.00	0.00
RADIOLOGY THERAPEUTIC	192,211.00	889.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	565,240.00	448.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	462,969.00	2,495.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,172.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	422.00	41,174.00	TRAUMA RESPONSE	0.00	46,180.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,852,247.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	391,385.00	13,544.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,408,214.50	35,189.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	260,858.00	9,741.00			
AUDIOLOGY	92,107.00	0.00			
CARDIOLOGY	1,019,405.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,682,056.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	488,713.50	486,949.50			

TOTAL ANCILLARY	131,698,714.74	1,183,137.61
TOTAL ACCOMODATIONS	50,199,391.00	4,712,470.00
TOTAL CHARGES	181,898,105.74	5,895,607.61

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,955,262.60	ADJUSTMENTS	0.00
COVERED CHARGES	4,823,465.10	CONTRACTUAL ALLOW	1,998,292.58
NON-COVERD CHARGES	131,797.50	TOTAL MEDICAID LIAB	2,825,172.52
		LESS: COB	2,825,172.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 46

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	201	0	318,173.50	113,897.50
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	201	0	318,173.50	113,897.50
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	230	0	1,071,912.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	230	0	1,071,912.00	0.00
TOTAL ACCOMODATIONS	431	0	1,390,085.50	113,897.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622,040.00	0.00	OTHER LAB	11,017.50	0.00
MED/SURG SUPPLY	214,170.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	318,029.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,039.50	0.00	OTHER THERAPEUTIC SVC	0.00	4,312.50
CT SCAN	45,880.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,356.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,034.00	0.00	MRI SERVICES	105,632.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	13,086.50
OPERATING ROOM	461,229.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	811,415.83	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	195,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,639.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	53,390.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,125.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,328.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	220,584.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,481.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,978.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	331.50	0.00			
CARDIOLOGY	14,434.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	165,550.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,450.00	310.00			

TOTAL ANCILLARY	3,433,379.60	17,900.00
TOTAL ACCOMODATIONS	1,390,085.50	113,897.50
TOTAL CHARGES	4,823,465.10	131,797.50

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 01/01/18 THROUGH 12/31/18
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
932	2019155078811	10/11/18 - 11/06/18	06/10/19	0.00	0.00	0.00	267,198.90	0.00
TOTAL				0.00	0.00	0.00	267,198.90	0.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,759,639.83	ADJUSTMENTS	2,272,115.29
COVERED CHARGES	59,825,067.04	CONTRACTUAL ALLOW	45,305,094.87
NON-COVERD CHARGES	6,934,572.79	TOTAL MEDICAID LIAB	14,519,972.17
		LESS: COB	46,883.89
		LESS: COPAYMENT	477.07
		REIMBURSEMENT	14,472,611.21
		ALL OTHER	12,937,366.43
		FEE SCHEDULE-LAB	597,094.64
		INJECTABLE DRUGS	938,150.14

TOTAL NUMBER OF CLAIMS 23,240

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,156,297.75	5,436.75	OTHER LAB	431,428.50	4,595.00
MED/SURG SUPPLY	3,316,213.98	35,207.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,874,134.00	26,609.50	OTHER THERAPEUTIC SVC	0.00	11,137.00
CT SCAN	1,853,120.50	238,158.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,876,951.50	64,915.00	FEE SCHEDULE LAB	11,233,371.96	958,269.00
EKG/ECG	38,434.00	229.50	MRI SERVICES	4,656,111.00	286,241.00
IV THERAPY	1,316,107.50	45,030.00	PROFESSIONAL FEES	0.00	10,722.50
OPERATING ROOM	6,463,243.50	742,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	421,681.91	96,795.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,908,423.00	12,205.50	AMBULANCE	0.00	0.00
GI SERVICES	142,661.50	17,252.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,416,421.50	132,847.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	769,178.00	1,740.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,246,361.00	2,338,220.25
RADIOLOGY THERAPEUTIC	623,253.50	13,288.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	776,529.03	51,138.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	808,729.50	104,996.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,118,919.00	304,136.50	TRAUMA RESPONSE	0.00	57,818.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	247,792.16	242,526.18
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	772,141.50	44,234.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,151,381.00	9,736.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	161,315.00	16,226.50			
AUDIOLOGY	346,828.25	24,827.00			
CARDIOLOGY	109,990.50	52,162.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,119,535.00	3,383.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,468,511.50	982,302.00			

TOTAL ANCILLARY	59,825,067.04	6,934,572.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,825,067.04	6,934,572.79

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,166,143.19	ADJUSTMENTS	0.00
COVERED CHARGES	1,625,595.88	CONTRACTUAL ALLOW	506,415.02
NON-COVERD CHARGES	540,547.31	TOTAL MEDICAID LIAB	1,119,180.86
		LESS: COB	1,119,174.86
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 528

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,490.75	0.00	OTHER LAB	2,134.00	0.00
MED/SURG SUPPLY	145,288.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,120.50	673.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,963.00	12,506.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,055.00	336.00	FEE SCHEDULE LAB	247,194.37	12,730.50
EKG/ECG	0.00	0.00	MRI SERVICES	106,067.50	118,853.50
IV THERAPY	6,080.00	2,973.00	PROFESSIONAL FEES	0.00	4,782.50
OPERATING ROOM	233,346.50	150,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,820.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	201,401.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,031.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,385.50	382.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,472.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140,116.00	121,507.25
RADIOLOGY THERAPEUTIC	93,365.00	1,280.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,496.00	672.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,849.00	3,037.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,474.00	14,068.00	TRAUMA RESPONSE	0.00	1,288.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,904.93	80,842.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,994.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,949.00	9,636.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,361.00	0.00			
AUDIOLOGY	4,220.00	2,486.50			
CARDIOLOGY	2,602.00	1,691.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	86,704.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,710.00	0.00			

TOTAL ANCILLARY	1,625,595.88	540,547.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,625,595.88	540,547.31

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,399,643.22	ADJUSTMENTS	21,459.22
COVERED CHARGES	1,272,060.17	CONTRACTUAL ALLOW	1,213,467.61
NON-COVERD CHARGES	127,583.05	TOTAL MEDICAID LIAB	58,592.56
		LESS: COB	19.19
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	58,570.37

TOTAL NUMBER OF CLAIMS 947

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,097.50	128.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,974.15	478.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,317.50	5,540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,377.50	41,158.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	281,026.87	59,764.50
EKG/ECG	2,453.50	0.00	MRI SERVICES	1,853.50	1,853.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,954.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	839.00	296.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	853.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	767,266.50	5,807.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,004.75	3,375.75
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	1,708.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	493.00	0.00	TRAUMA RESPONSE	0.00	1,288.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,058.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,566.00	2,774.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	600.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,123.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,547.50	3,410.00			

TOTAL ANCILLARY	1,272,060.17	127,583.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,272,060.17	127,583.05

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,974.66	ADJUSTMENTS	0.00
COVERED CHARGES	27,895.41	CONTRACTUAL ALLOW	13,770.38
NON-COVERD CHARGES	7,079.25	TOTAL MEDICAID LIAB	14,125.03
		LESS: COB	14,125.03
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	283.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,514.00	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	11,828.50	976.00
EKG/ECG	350.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	4,170.50
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	13,445.00	244.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285.75	70.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,617.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,895.41	7,079.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,895.41	7,079.25

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,859,635.39	ADJUSTMENTS	307,328.67
COVERED CHARGES	7,894,944.29	CONTRACTUAL ALLOW	6,419,453.88
NON-COVERD CHARGES	964,691.10	TOTAL MEDICAID LIAB	1,475,490.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,475,490.41

TOTAL NUMBER OF CLAIMS 178

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,280.00	0.00	OTHER LAB	0.00	7,834.00
MED/SURG SUPPLY	869,040.77	194.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,336.00	3,439.00	OTHER THERAPEUTIC SVC	0.00	184.00
CT SCAN	45,297.00	9,086.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,936.50	7,840.00	FEE SCHEDULE LAB	204,099.60	7,140.75
EKG/ECG	1,402.00	350.50	MRI SERVICES	62,463.50	10,158.00
IV THERAPY	58,591.50	1,526.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,404,565.50	547,740.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,420.18	10,865.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	953,791.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,231.50	3,740.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,936.50	1,107.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	124,127.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,056,203.50	78,269.25
RADIOLOGY THERAPEUTIC	39,760.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,179.00	2,808.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,705.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,837.50	7,179.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,469,175.24	161,684.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,257.50	582.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	111.00	222.00			
CARDIOLOGY	2,779.00	9,812.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	198,464.50	3,350.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,703.00	88,883.00			

TOTAL ANCILLARY	7,894,944.29	964,691.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,894,944.29	964,691.10

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,230.29	ADJUSTMENTS	0.00
COVERED CHARGES	48,608.54	CONTRACTUAL ALLOW	10,202.02
NON-COVERD CHARGES	12,621.75	TOTAL MEDICAID LIAB	38,406.52
		LESS: COB	38,406.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	687.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,827.95	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	1,158.50	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	12,231.50	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	4,443.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,663.50	199.25
RADIOLOGY THERAPEUTIC	1,275.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,427.59	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,472.50	0.00			

TOTAL ANCILLARY	48,608.54	12,621.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,608.54	12,621.75

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,153.48	ADJUSTMENTS	0.00
COVERED CHARGES	49,588.48	CONTRACTUAL ALLOW	42,818.51
NON-COVERD CHARGES	565.00	TOTAL MEDICAID LIAB	6,769.97
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,769.97

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	8,428.00	565.00
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	8,428.00	565.00
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	8,428.00	565.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,378.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,961.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,628.67	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,783.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,065.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	921.50	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	8,519.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,902.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,160.48	0.00
TOTAL ACCOMODATIONS	8,428.00	565.00
TOTAL CHARGES	49,588.48	565.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,312,078.00	ADJUSTMENTS	39,036.38
COVERED CHARGES	2,201,056.74	CONTRACTUAL ALLOW	1,936,359.34
NON-COVERD CHARGES	111,021.26	TOTAL MEDICAID LIAB	264,697.40
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	264,514.40
		ALL OTHER	246,804.27
		FEE SCHEDULE-LAB	15,903.25
		INJECTABLE DRUGS	1,806.88

TOTAL NUMBER OF CLAIMS 916

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,813.61	87.50	OTHER LAB	3,968.80	0.00
MED/SURG SUPPLY	23,440.14	544.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,271.35	5,229.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	257,040.30	70,263.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,019.20	588.00	FEE SCHEDULE LAB	311,135.35	6,183.29
EKG/ECG	42,615.00	819.00	MRI SERVICES	0.00	0.00
IV THERAPY	133,137.50	4,878.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	435.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,981.50	7,779.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,055,133.05	2,786.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,672.04	8,893.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,426.00	2,352.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111.00	615.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,745.50	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	111.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,201,056.74	111,021.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,201,056.74	111,021.26

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338.00	ADJUSTMENTS	0.00
COVERED CHARGES	338.00	CONTRACTUAL ALLOW	86.02
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	251.98
		LESS: COB	251.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	338.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	338.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338.00	0.00

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	295,926.50	ADJUSTMENTS	0.00
COVERED CHARGES	286,036.30	CONTRACTUAL ALLOW	277,636.30
NON-COVERD CHARGES	9,890.20	TOTAL MEDICAID LIAB	8,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	8,064.00
		TOTAL NUMBER OF CLAIMS	168

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,910.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,563.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,423.09	1,154.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,484.50	7,143.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,043.88	1,063.25
EKG/ECG	2,150.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,651.50	143.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	281.10	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	181,966.00	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	9,562.16	384.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	286,036.30	9,890.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	286,036.30	9,890.20

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	199,333.76	ADJUSTMENTS	0.00
COVERED CHARGES	182,356.76	CONTRACTUAL ALLOW	109,506.62
NON-COVERD CHARGES	16,977.00	TOTAL MEDICAID LIAB	72,850.14
		LESS: COB	555.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	72,294.67

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	102	0	76,500.00	15,550.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	102	0	76,500.00	15,550.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	102	0	76,500.00	15,550.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,120.00	234.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,300.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,696.00	477.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,755.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	805.00	285.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,140.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	325.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,955.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,391.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,147.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	506.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	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	2,126.02	0.00			

TOTAL ANCILLARY	105,856.76	1,427.00
TOTAL ACCOMODATIONS	76,500.00	15,550.00
TOTAL CHARGES	182,356.76	16,977.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	367,480.72	ADJUSTMENTS	6,536.39
COVERED CHARGES	314,394.50	CONTRACTUAL ALLOW	209,884.19
NON-COVERD CHARGES	53,086.22	TOTAL MEDICAID LIAB	104,510.31
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	104,195.31
		ALL OTHER	86,829.64
		FEE SCHEDULE-LAB	17,068.87
		INJECTABLE DRUGS	296.80

TOTAL NUMBER OF CLAIMS 357

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,275.00	4,704.00	OTHER LAB	11,105.00	0.00
MED/SURG SUPPLY	600.00	77.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,225.00	8,220.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,275.00	8,950.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,825.00	1,137.00	FEE SCHEDULE LAB	105,431.20	4,596.00
EKG/ECG	3,393.00	990.00	MRI SERVICES	13,475.00	1,500.00
IV THERAPY	4,020.00	1,410.00	PROFESSIONAL FEES	0.00	360.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,557.00	1,432.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,600.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,502.26	1,784.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,248.00	2,083.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	188.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	508.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,910.00	1,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,217.00	6,234.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,648.00	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	4,688.04	563.22			

TOTAL ANCILLARY	314,394.50	53,086.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	314,394.50	53,086.22

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,883.14	ADJUSTMENTS	0.00
COVERED CHARGES	13,995.14	CONTRACTUAL ALLOW	12,895.14
NON-COVERD CHARGES	888.00	TOTAL MEDICAID LIAB	1,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	1,070.00
		TOTAL NUMBER OF CLAIMS	22

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397.00	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	525.00	275.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,584.00	213.00
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	7,985.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	529.00	273.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	127.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,995.14	888.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,995.14	888.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,635,916.69	ADJUSTMENTS	111,631.22
COVERED CHARGES	2,623,845.69	CONTRACTUAL ALLOW	2,286,475.99
NON-COVERD CHARGES	12,071.00	TOTAL MEDICAID LIAB	337,369.70
		LESS: COB	4,702.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	332,667.07

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	95	0	122,740.00	8,930.00
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	95	0	122,740.00	8,930.00
SPECIAL CARE SERVICES				
CCU	262	0	658,668.00	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	262	0	658,668.00	0.00
TOTAL ACCOMODATIONS	357	0	781,408.00	8,930.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	372,173.50	0.00	OTHER LAB	19,119.00	0.00
MED/SURG SUPPLY	78,263.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	203,915.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,164.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,141.00
CT SCAN	30,769.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	59,287.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,633.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	841,170.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,262.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	466.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	557.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,347.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	38,285.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	222.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,841.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,242.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,002.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,884.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,699.00	0.00			

TOTAL ANCILLARY	1,842,437.69	3,141.00
TOTAL ACCOMODATIONS	781,408.00	8,930.00
TOTAL CHARGES	2,623,845.69	12,071.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,992,097.58	ADJUSTMENTS	89,939.31
COVERED CHARGES	2,775,022.58	CONTRACTUAL ALLOW	2,185,609.47
NON-COVERD CHARGES	217,075.00	TOTAL MEDICAID LIAB	589,413.11
		LESS: COB	4,160.81
		LESS: COPAYMENT	2,871.00
		REIMBURSEMENT	582,381.30
		ALL OTHER	519,240.37
		FEE SCHEDULE-LAB	827.46
		INJECTABLE DRUGS	62,313.47

TOTAL NUMBER OF CLAIMS 605

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,889.75	60.00	OTHER LAB	13,579.00	0.00
MED/SURG SUPPLY	61,394.90	530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,405.00	2,396.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	204,843.00	13,039.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	573,730.00	67,374.00	FEE SCHEDULE LAB	14,991.00	1,598.00
EKG/ECG	1,108.00	0.00	MRI SERVICES	154,898.00	8,487.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	468,261.00	107,819.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	228,260.00	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	115,129.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,730.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,042.00	374.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	30,979.68	3,318.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	60,114.00	988.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,726.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,821.00	4,516.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	429,737.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,775,022.58	217,075.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,775,022.58	217,075.00

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,972.54	ADJUSTMENTS	0.00
COVERED CHARGES	116,832.88	CONTRACTUAL ALLOW	48,107.21
NON-COVERD CHARGES	54,139.66	TOTAL MEDICAID LIAB	68,725.67
		LESS: COB	68,713.67
		LESS: COPAYMENT	12.00
		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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,779.00	60.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,989.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,211.00	476.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.00	FEE SCHEDULE LAB	253.00	0.00
EKG/ECG	92.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,349.00	47,434.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,414.00	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	9,952.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,002.00	265.50
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	10,008.52	5,228.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,425.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	870.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	116,832.88	54,139.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	116,832.88	54,139.66

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	586,835.34	ADJUSTMENTS	47,694.84
COVERED CHARGES	560,558.24	CONTRACTUAL ALLOW	494,957.21
NON-COVERD CHARGES	26,277.10	TOTAL MEDICAID LIAB	65,601.03
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	65,580.03
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,094.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,515.30	5,674.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,396.00	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	338.00	FEE SCHEDULE LAB	796.00	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	110,940.00	6,826.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,131.00	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	15,993.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,659.75	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	219,683.94	13,437.90
LITHOTRIPSY	77,349.00	1.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	560,558.24	26,277.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	560,558.24	26,277.10

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,564,829.16	ADJUSTMENTS	516,097.65
COVERED CHARGES	18,957,185.86	CONTRACTUAL ALLOW	13,643,387.64
NON-COVERD CHARGES	607,643.30	TOTAL MEDICAID LIAB	5,313,798.22
		LESS: COB	84,674.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,229,123.58

TOTAL NUMBER OF ADMISSIONS 598

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	897	0	864,830.00	171,219.00
ROUTINE NURSERY	203	0	207,353.00	20,827.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,100	0	1,072,183.00	192,046.00
SPECIAL CARE SERVICES				
CCU	1,082	0	2,062,656.00	0.00
ICU	445	0	1,207,036.00	44,889.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,527	0	3,269,692.00	44,889.00
TOTAL ACCOMODATIONS	2,627	0	4,341,875.00	236,935.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,770,873.21	78,321.25	OTHER LAB	107,717.30	0.00
MED/SURG SUPPLY	617,367.56	5,227.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,717,195.13	42,897.00	EDUCATION & TRAINING	1,494.60	0.00
RADIOLOGY-DIAGNOSTIC	311,502.50	6,774.00	OTHER THERAPEUTIC SVC	0.00	1,053.80
CT SCAN	1,209,386.60	40,649.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	113,665.35	523.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	263,016.75	1,536.00	MRI SERVICES	181,487.00	0.00
IV THERAPY	176,698.40	1,199.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,332,551.90	20,465.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	253,893.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,130,392.70	1,963.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343,843.43	2,579.00	AMBULANCE	0.00	0.00
GI SERVICES	77,702.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,198,345.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	147,299.00	72.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	123,792.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	105,283.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,290.82	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,877.20	0.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	166,229.60	78,473.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,006.90	762.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	432,746.39	861.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	129,460.40	8,375.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	207,338.80	64,099.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	171,079.40	14,878.20			
AUDIOLOGY	7,729.80	0.00			
CARDIOLOGY	1,194,845.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94,064.17	0.00			

TOTAL ANCILLARY	14,615,310.86	370,708.30
TOTAL ACCOMODATIONS	4,341,875.00	236,935.00
TOTAL CHARGES	18,957,185.86	607,643.30

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,273.74	ADJUSTMENTS	0.00
COVERED CHARGES	85,299.74	CONTRACTUAL ALLOW	60,544.88
NON-COVERD CHARGES	2,974.00	TOTAL MEDICAID LIAB	24,754.86
		LESS: COB	24,754.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10	0	9,850.00	2,974.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	9,850.00	2,974.00
SPECIAL CARE SERVICES				
CCU	1	0	2,514.00	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	2,514.00	0.00
TOTAL ACCOMODATIONS	11	0	12,364.00	2,974.00

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
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,297.15	0.00	OTHER LAB	12,317.00	0.00
MED/SURG SUPPLY	2,076.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,857.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,364.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,667.20	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	1,649.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,798.00	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	6,715.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	668.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,334.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,191.50	0.00			

TOTAL ANCILLARY	72,935.74	0.00
TOTAL ACCOMODATIONS	12,364.00	2,974.00
TOTAL CHARGES	85,299.74	2,974.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,976,796.34	ADJUSTMENTS	496,830.13
COVERED CHARGES	16,194,154.90	CONTRACTUAL ALLOW	13,549,410.43
NON-COVERD CHARGES	1,782,641.44	TOTAL MEDICAID LIAB	2,644,744.47
		LESS: COB	7,435.30
		LESS: COPAYMENT	4,800.00
		REIMBURSEMENT	2,632,509.17
		ALL OTHER	2,312,688.83
		FEE SCHEDULE-LAB	220,389.11
		INJECTABLE DRUGS	99,431.23

TOTAL NUMBER OF CLAIMS 5,783

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,002.77	0.00	OTHER LAB	240,883.20	1,556.00
MED/SURG SUPPLY	356,112.16	88,018.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	179.20
RADIOLOGY-DIAGNOSTIC	605,369.00	48,277.40	OTHER THERAPEUTIC SVC	0.00	961.60
CT SCAN	1,690,751.20	271,965.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,526.30	4,175.70	FEE SCHEDULE LAB	2,986,119.62	139,134.60
EKG/ECG	301,626.65	25,086.50	MRI SERVICES	152,500.00	27,070.00
IV THERAPY	577,099.80	42,483.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,257,100.71	190,030.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,088.30	0.00	REHAB THERAPY	0.00	6,836.20
RESPIRATORY SERVICES	177,362.30	15,212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	513,561.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	127,455.50	22,626.20	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,818,458.07	92,194.93	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	248,447.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	342,608.82	282,662.69
RADIOLOGY THERAPEUTIC	329,030.90	201,317.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,393.00	496.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	847.00	0.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,685.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,721.80	2,775.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,602.20	420.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	398,356.30	46,238.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,837.70	3,789.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	269,138.40	71,554.10			
AUDIOLOGY	572.20	204.40			
CARDIOLOGY	717,657.30	174,368.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	142,131.00	1,027.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	417,793.90	19,293.90			

TOTAL ANCILLARY	16,194,154.90	1,782,641.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,194,154.90	1,782,641.44

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	279,118.76	ADJUSTMENTS	0.00
COVERED CHARGES	229,505.21	CONTRACTUAL ALLOW	89,947.95
NON-COVERD CHARGES	49,613.55	TOTAL MEDICAID LIAB	139,557.26
		LESS: COB	139,536.26
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,410.01	0.00	OTHER LAB	6,859.20	0.00
MED/SURG SUPPLY	8,408.35	1,991.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,399.70	5,468.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,544.00	16,038.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	47,977.40	1,028.20
EKG/ECG	3,437.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,696.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,709.75	13,907.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	864.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,205.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,031.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,501.50	1,009.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,173.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	889.60	267.75
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	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,397.00	9,792.20			
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			

TOTAL ANCILLARY	229,505.21	49,613.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,505.21	49,613.55

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,313,275.45	ADJUSTMENTS	539.54
COVERED CHARGES	1,251,990.70	CONTRACTUAL ALLOW	1,207,686.22
NON-COVERD CHARGES	61,284.75	TOTAL MEDICAID LIAB	44,304.48
		LESS: COB	1.86
		LESS: COPAYMENT	1,461.00
		REIMBURSEMENT	42,841.62
		TOTAL NUMBER OF CLAIMS	792

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,895.90	0.00	OTHER LAB	4,906.00	0.00
MED/SURG SUPPLY	4,264.30	59.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,955.40	12,307.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	120,531.40	21,008.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	201,336.40	7,906.00
EKG/ECG	22,673.00	687.50	MRI SERVICES	0.00	0.00
IV THERAPY	11,806.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,723.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,991.60	1,733.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	763,212.70	11,370.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,329.80	1,051.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,962.70	4,938.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,401.90	0.00			

TOTAL ANCILLARY	1,251,990.70	61,284.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,251,990.70	61,284.75

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,649.55	ADJUSTMENTS	0.00
COVERED CHARGES	19,426.95	CONTRACTUAL ALLOW	9,080.75
NON-COVERD CHARGES	1,222.60	TOTAL MEDICAID LIAB	10,346.20
		LESS: COB	10,334.20
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	381.50	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	545.00	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	5,562.50	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	12,875.70	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	62.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,222.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,426.95	1,222.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,426.95	1,222.60

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,442,781.28	ADJUSTMENTS	193,160.28
COVERED CHARGES	2,271,041.76	CONTRACTUAL ALLOW	1,899,511.35
NON-COVERD CHARGES	171,739.52	TOTAL MEDICAID LIAB	371,530.41
		LESS: COB	592.77
		LESS: COPAYMENT	717.00
		REIMBURSEMENT	370,220.64

TOTAL NUMBER OF CLAIMS 67

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,713.74	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	253,970.94	686.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,899.00	709.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,189.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	989.42	FEE SCHEDULE LAB	44,389.70	1,369.40
EKG/ECG	2,223.50	2,406.25	MRI SERVICES	0.00	0.00
IV THERAPY	96,972.30	2,611.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	311,818.80	25,728.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	964.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,146.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,033.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	615,410.26	36,526.35
RADIOLOGY THERAPEUTIC	658,977.00	61,038.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,518.80	111.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,364.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,199.90	3,066.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,723.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,880.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	113,748.60	35,103.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,897.62	1,393.00			

TOTAL ANCILLARY	2,271,041.76	171,739.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,271,041.76	171,739.52

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	665,304.07	ADJUSTMENTS	20,327.00
COVERED CHARGES	634,736.07	CONTRACTUAL ALLOW	429,207.26
NON-COVERD CHARGES	30,568.00	TOTAL MEDICAID LIAB	205,528.81
		LESS: COB	1,880.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	203,648.23

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	164	0	82,000.00	25,710.00
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	164	0	82,000.00	25,710.00
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	164	0	82,000.00	25,710.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,358.07	0.00	OTHER LAB	474.00	0.00
MED/SURG SUPPLY	52,959.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,258.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,626.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,933.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,713.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,546.00	246.00	MRI SERVICES	1,503.00	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	218,447.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,147.00	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	1,608.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	404.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,114.00	4,612.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,976.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,670.00	0.00			

TOTAL ANCILLARY	552,736.07	4,858.00
TOTAL ACCOMODATIONS	82,000.00	25,710.00
TOTAL CHARGES	634,736.07	30,568.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	789,275.75	ADJUSTMENTS	49,603.43
COVERED CHARGES	700,124.75	CONTRACTUAL ALLOW	395,553.63
NON-COVERD CHARGES	89,151.00	TOTAL MEDICAID LIAB	304,571.12
		LESS: COB	400.00
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	303,565.12
		ALL OTHER	275,398.59
		FEE SCHEDULE-LAB	26,810.82
		INJECTABLE DRUGS	1,355.71

TOTAL NUMBER OF CLAIMS 756

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,915.75	4,881.00	OTHER LAB	7,070.00	0.00
MED/SURG SUPPLY	45,970.00	660.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,268.00	8,317.00	OTHER THERAPEUTIC SVC	0.00	162.00
CT SCAN	84,694.00	6,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,968.00	100.00	FEE SCHEDULE LAB	127,507.00	10,667.00
EKG/ECG	10,256.00	582.00	MRI SERVICES	5,520.00	0.00
IV THERAPY	0.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,774.00	3,543.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,246.00	18,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	242,032.00	18,210.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,864.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,608.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	250.00	560.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,315.00	1,601.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,552.00	412.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,568.00	1,153.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,902.00	7,814.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,640.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,205.00	5,668.00			

TOTAL ANCILLARY	700,124.75	89,151.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	700,124.75	89,151.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,140.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,383.00	CONTRACTUAL ALLOW	1,294.83
NON-COVERD CHARGES	6,757.00	TOTAL MEDICAID LIAB	11,088.17
		LESS: COB	11,085.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	941.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,092.00	8.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	273.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,029.00	4,530.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,279.00	134.00
EKG/ECG	291.00	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	2,778.00	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	5.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,744.00			
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	792.00	68.00			

TOTAL ANCILLARY	12,383.00	6,757.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,383.00	6,757.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,552.50	ADJUSTMENTS	50.00
COVERED CHARGES	55,573.50	CONTRACTUAL ALLOW	51,073.50
NON-COVERD CHARGES	979.00	TOTAL MEDICAID LIAB	4,500.00
		LESS: COB	18.56
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	4,265.44
		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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,305.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,735.00	8.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,050.00	176.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,879.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,944.00	795.00
EKG/ECG	287.00	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	485.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	446.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	90.00	0.00			

TOTAL ANCILLARY	55,573.50	979.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,573.50	979.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,175.00	ADJUSTMENTS	4,862.89
COVERED CHARGES	34,573.00	CONTRACTUAL ALLOW	19,984.33
NON-COVERD CHARGES	602.00	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	14,585.67

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,035.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,273.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	519.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,095.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,034.00	83.00
EKG/ECG	97.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,297.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,760.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	262.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	544.00	0.00			

TOTAL ANCILLARY	34,573.00	602.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,573.00	602.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,740,210.13	ADJUSTMENTS	0.00
COVERED CHARGES	4,555,571.13	CONTRACTUAL ALLOW	3,474,000.34
NON-COVERD CHARGES	184,639.00	TOTAL MEDICAID LIAB	1,081,570.79
		LESS: COB	10,256.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,071,314.70

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	346	0	266,874.00	157,742.00
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	346	0	266,874.00	157,742.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	77	0	195,255.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	77	0	195,255.00	0.00
TOTAL ACCOMODATIONS	423	0	462,129.00	157,742.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	717,735.00	0.00	OTHER LAB	15,525.00	0.00
MED/SURG SUPPLY	253,171.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	682,282.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	520,277.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,583.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	55,080.00	0.00	MRI SERVICES	44,061.00	0.00
IV THERAPY	219,334.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,401.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	440,367.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,622.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	245,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,735.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	33,527.00	0.00	INJECTABLE DRUGS	15,325.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,166.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,578.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	452.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	196,461.77	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,683.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,882.00	12,887.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,305.00	8,694.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	126,757.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,967.00	5,316.00			

TOTAL ANCILLARY	4,093,442.13	26,897.00
TOTAL ACCOMODATIONS	462,129.00	157,742.00
TOTAL CHARGES	4,555,571.13	184,639.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,848.00	ADJUSTMENTS	0.00
COVERED CHARGES	74,890.00	CONTRACTUAL ALLOW	53,989.30
NON-COVERD CHARGES	958.00	TOTAL MEDICAID LIAB	20,900.70
		LESS: COB	20,900.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,496.00	958.00
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	1,496.00	958.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	10,260.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	10,260.00	0.00
TOTAL ACCOMODATIONS	6	0	11,756.00	958.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,490.00	0.00	OTHER LAB	1,366.00	0.00
MED/SURG SUPPLY	4,195.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,314.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,153.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,772.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	13,419.00	0.00
IV THERAPY	2,119.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,407.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,668.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,619.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	63,134.00	0.00
TOTAL ACCOMODATIONS	11,756.00	958.00
TOTAL CHARGES	74,890.00	958.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,302,597.59	ADJUSTMENTS	179,571.55
COVERED CHARGES	7,314,387.43	CONTRACTUAL ALLOW	5,949,399.73
NON-COVERD CHARGES	988,210.16	TOTAL MEDICAID LIAB	1,364,987.70
		LESS: COB	831.34
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	1,362,476.36
		ALL OTHER	1,272,209.90
		FEE SCHEDULE-LAB	80,398.88
		INJECTABLE DRUGS	9,867.58

TOTAL NUMBER OF CLAIMS 2,076

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,618.00	95,884.00	OTHER LAB	44,595.00	0.00
MED/SURG SUPPLY	121,642.64	5,415.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	337,980.00	62,128.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,767,772.00	190,874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,492.00	FEE SCHEDULE LAB	994,279.79	125,427.40
EKG/ECG	115,387.00	2,142.00	MRI SERVICES	218,363.00	15,406.00
IV THERAPY	569,077.00	57,927.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205,605.84	172,410.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,629.00	9,307.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	150,825.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,751,893.00	1,622.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	275,251.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227,983.00	91,955.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,070.00	7,198.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	197.16	61,136.15
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	119,444.00	10,710.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,034.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,303.00	27,408.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,153.00	26,195.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	181,285.00	23,573.00			

TOTAL ANCILLARY	7,314,387.43	988,210.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,314,387.43	988,210.16

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 BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,050.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,828.00	CONTRACTUAL ALLOW	17,227.20
NON-COVERD CHARGES	6,222.00	TOTAL MEDICAID LIAB	19,600.80
		LESS: COB	19,600.80
		LESS: COPAYMENT	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	442.00	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	3,566.00	1,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,550.00	4,510.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,475.00	72.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,116.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,692.00	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	89.00	126.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,828.00	6,222.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,828.00	6,222.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	281,070.00	ADJUSTMENTS	1,895.77
COVERED CHARGES	265,721.00	CONTRACTUAL ALLOW	255,819.55
NON-COVERD CHARGES	15,349.00	TOTAL MEDICAID LIAB	9,901.45
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	9,637.45
		TOTAL NUMBER OF CLAIMS	170

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	766.00	816.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	191.00	370.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,246.00	4,647.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,274.00	2,255.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,601.00	2,210.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,265.00	1,216.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,567.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,909.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,104.00	1,977.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	761.00	1,858.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,425.00	0.00			

TOTAL ANCILLARY	265,721.00	15,349.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	265,721.00	15,349.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,470.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,046.00	CONTRACTUAL ALLOW	7,670.57
NON-COVERD CHARGES	2,424.00	TOTAL MEDICAID LIAB	4,375.43
		LESS: COB	4,372.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,059.00	2,255.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,284.00	72.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,208.00	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	2,872.00	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	473.00	97.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,046.00	2,424.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,046.00	2,424.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	950,145.39	ADJUSTMENTS	43,503.80
COVERED CHARGES	725,397.75	CONTRACTUAL ALLOW	600,263.95
NON-COVERD CHARGES	224,747.64	TOTAL MEDICAID LIAB	125,133.80
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	125,082.80
		TOTAL NUMBER OF CLAIMS	23

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,017.00	3,134.00	OTHER LAB	2,564.00	0.00
MED/SURG SUPPLY	92,525.37	4,315.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,091.00	862.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,772.00	7,307.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,486.00	6,121.00
EKG/ECG	5,202.00	0.00	MRI SERVICES	7,997.00	0.00
IV THERAPY	41,861.00	11,782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,674.67	71,863.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,327.00	2,217.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,747.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,620.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	99,636.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,381.00	10,385.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,519.71	70,485.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,640.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,288.00	10,527.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,974.00	6,859.00			
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	15,075.00	18,777.00			

TOTAL ANCILLARY	725,397.75	224,747.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	725,397.75	224,747.64

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,652,897.54	ADJUSTMENTS	9,006.13
COVERED CHARGES	9,617,196.30	CONTRACTUAL ALLOW	7,472,658.06
NON-COVERD CHARGES	35,701.24	TOTAL MEDICAID LIAB	2,144,538.24
		LESS: COB	1,967.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,142,570.74

TOTAL NUMBER OF ADMISSIONS 299

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	881	0	1,122,394.00	2,205.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	881	0	1,122,394.00	2,205.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	881	0	1,122,394.00	2,205.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	763,043.00	0.00	OTHER LAB	3,753.00	0.00
MED/SURG SUPPLY	124,398.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	862,088.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,688.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,856.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,282.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,860.00	0.00	MRI SERVICES	10,717.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,696.24
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,292,368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,091,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,245.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	324.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	17,481.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,022.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,337.00	4,192.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,220.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,960.80	10,127.00			

TOTAL ANCILLARY	8,494,802.30	33,496.24
TOTAL ACCOMODATIONS	1,122,394.00	2,205.00
TOTAL CHARGES	9,617,196.30	35,701.24

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,688.50	ADJUSTMENTS	0.00
COVERED CHARGES	27,688.50	CONTRACTUAL ALLOW	17,433.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,254.55
		LESS: COB	10,254.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	6,370.00	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	6,370.00	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	0	6,370.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,930.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	200.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,808.00	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	11,677.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,703.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,318.50	0.00
TOTAL ACCOMODATIONS	6,370.00	0.00
TOTAL CHARGES	27,688.50	0.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,126,369.72	ADJUSTMENTS	334,827.17
COVERED CHARGES	21,490,564.15	CONTRACTUAL ALLOW	17,187,012.81
NON-COVERD CHARGES	1,635,805.57	TOTAL MEDICAID LIAB	4,303,551.34
		LESS: COB	14,915.60
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	4,288,614.74
		ALL OTHER	3,724,439.68
		FEE SCHEDULE-LAB	155,928.30
		INJECTABLE DRUGS	408,246.76

TOTAL NUMBER OF CLAIMS 10,846

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,174.50	0.00	OTHER LAB	240,671.00	23,862.00
MED/SURG SUPPLY	407,255.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	772,742.00	9,481.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	131,002.00	7,428.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,050,739.50	288,929.00
EKG/ECG	42,687.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,484.00	0.00	PROFESSIONAL FEES	0.00	1,815.91
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,090,195.02	605,268.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,307,272.64	104,430.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,467,137.39	177,160.98
RADIOLOGY THERAPEUTIC	19,764.00	648.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.23
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,845,870.50	387,769.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,400.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,903.50
OTHER IMAGING SERVICE	126,396.00	9,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	314,674.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	720.00	30.00			
CARDIOLOGY	43,963.00	13,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	239,416.60	3,890.90			

TOTAL ANCILLARY	21,490,564.15	1,635,805.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,490,564.15	1,635,805.57

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 01/01/18 THROUGH 12/31/18
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	2018195010171	02/21/18 - 02/21/18	07/23/18	0.00	951.75	0.00	0.00	0.00
970	2019008072378	10/08/18 - 10/08/18	01/14/19	0.00	951.75	0.00	0.00	0.00
TOTAL				0.00	1,903.50	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	132,134.76	ADJUSTMENTS	0.00
COVERED CHARGES	118,143.26	CONTRACTUAL ALLOW	63,319.99
NON-COVERD CHARGES	13,991.50	TOTAL MEDICAID LIAB	54,823.27
		LESS: COB	54,823.27
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,027.75	0.00	OTHER LAB	2,466.00	0.00
MED/SURG SUPPLY	7,392.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,510.00	1,407.00	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	17,290.00	1,102.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	692.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,258.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,897.00	1,924.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223.50	153.50
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	22,341.00	3,719.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,898.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,738.00	2,096.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	118,143.26	13,991.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,143.26	13,991.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,885,138.90	ADJUSTMENTS	25,945.74
COVERED CHARGES	1,858,760.75	CONTRACTUAL ALLOW	1,790,688.35
NON-COVERD CHARGES	26,378.15	TOTAL MEDICAID LIAB	68,072.40
		LESS: COB	36.99
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	68,032.41
		TOTAL NUMBER OF CLAIMS	1,098

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,963.25	1,661.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,805.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,785.00	5,542.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	181,011.00	12,704.00
EKG/ECG	3,430.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	260.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,563.00	3,426.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,558,441.00	695.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,415.50	677.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	492.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,442.00	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	1,652.30	0.00			

TOTAL ANCILLARY	1,858,760.75	26,378.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,858,760.75	26,378.15

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,729.25	ADJUSTMENTS	0.00
COVERED CHARGES	21,490.50	CONTRACTUAL ALLOW	12,976.53
NON-COVERD CHARGES	238.75	TOTAL MEDICAID LIAB	8,513.97
		LESS: COB	8,513.97
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	526.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,962.00	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	562.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	198.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	576.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,854.00	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	10.50	40.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,490.50	238.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,490.50	238.75

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,112.83	ADJUSTMENTS	0.00
COVERED CHARGES	7,112.83	CONTRACTUAL ALLOW	4,693.65
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,419.18
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,419.18

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	1,038.00	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	1,038.00	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	1,038.00	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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	342.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	903.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	297.00	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	2,987.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,074.83	0.00
TOTAL ACCOMODATIONS	1,038.00	0.00
TOTAL CHARGES	7,112.83	0.00

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,727,631.30	ADJUSTMENTS	219.58
COVERED CHARGES	1,370,177.10	CONTRACTUAL ALLOW	1,077,008.85
NON-COVERD CHARGES	357,454.20	TOTAL MEDICAID LIAB	293,168.25
		LESS: COB	1,707.71
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	291,409.54
		ALL OTHER	254,748.69
		FEE SCHEDULE-LAB	32,096.37
		INJECTABLE DRUGS	4,564.48

TOTAL NUMBER OF CLAIMS 625

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,305.04	5,503.22	OTHER LAB	4,566.00	1,225.00
MED/SURG SUPPLY	1,939.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,299.00	38,129.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,574.00	190,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,943.00	FEE SCHEDULE LAB	356,048.00	30,601.00
EKG/ECG	32,305.00	3,550.00	MRI SERVICES	0.00	0.00
IV THERAPY	100,605.00	9,512.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,394.00	15,988.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	687,857.00	4,798.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,022.06	25,813.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	702.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,530.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,610.00	3,460.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	722.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	17,804.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,760.00	3,906.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,171.00	817.00			

TOTAL ANCILLARY	1,370,177.10	357,454.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,370,177.10	357,454.20

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,156.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,661.35	CONTRACTUAL ALLOW	-1,273.64
NON-COVERD CHARGES	4,494.65	TOTAL MEDICAID LIAB	9,934.99
		LESS: COB	9,934.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186.25	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	3,842.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,997.00	305.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	719.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,663.00	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	96.10	347.65
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,661.35	4,494.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,661.35	4,494.65

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	161,126.80	ADJUSTMENTS	0.00
COVERED CHARGES	140,474.55	CONTRACTUAL ALLOW	135,719.65
NON-COVERD CHARGES	20,652.25	TOTAL MEDICAID LIAB	4,754.90
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	4,562.90
		TOTAL NUMBER OF CLAIMS	85

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,230.30	0.00	OTHER LAB	761.00	0.00
MED/SURG SUPPLY	49.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,659.00	1,347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,515.00	15,495.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,010.00	1,906.00
EKG/ECG	1,420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,035.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	197.00	816.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,500.00	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	4,098.25	1,088.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	140,474.55	20,652.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	140,474.55	20,652.25

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,954,568.61	ADJUSTMENTS	69,658.82
COVERED CHARGES	7,932,412.61	CONTRACTUAL ALLOW	5,435,081.45
NON-COVERD CHARGES	22,156.00	TOTAL MEDICAID LIAB	2,497,331.16
		LESS: COB	36,483.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,460,847.56

TOTAL NUMBER OF ADMISSIONS 299

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	988	0	592,930.00	8,709.00
ROUTINE NURSERY	75	0	40,350.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,063	0	633,280.00	8,709.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	108	0	151,416.00	0.00
NICU	19	0	22,078.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	127	0	173,494.00	0.00
TOTAL ACCOMODATIONS	1,190	0	806,774.00	8,709.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697,025.36	0.00	OTHER LAB	26,990.00	0.00
MED/SURG SUPPLY	710,864.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	784,213.26	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150,795.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	402,551.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	141,120.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,626.00	0.00	MRI SERVICES	74,388.00	0.00
IV THERAPY	38,447.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	764,165.00	5,041.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,036.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	216,308.37	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	229,006.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	397,780.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	215,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	28,798.00	0.00	INJECTABLE DRUGS	1,068,486.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,232.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,413.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	229.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	652,553.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,242.00
OTHER IMAGING SERVICE	50,576.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	86,159.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,070.00	0.00			
AUDIOLOGY	20,384.00	0.00			
CARDIOLOGY	90,602.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,052.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,908.00	1,935.00			

TOTAL ANCILLARY	7,125,638.61	13,447.00
TOTAL ACCOMODATIONS	806,774.00	8,709.00
TOTAL CHARGES	7,932,412.61	22,156.00

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 08/01/17 THROUGH 07/31/18
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	2117353000037	10/16/17 - 10/18/17	01/01/18	0.00	3,121.00	0.00	1,522.17	0.00
615	2018198088637	10/11/17 - 10/14/17	07/23/18	0.00	3,121.00	0.00	0.00	0.00
TOTAL				0.00	6,242.00	0.00	1,522.17	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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,226,339.96	ADJUSTMENTS	491,436.94
COVERED CHARGES	8,608,089.75	CONTRACTUAL ALLOW	6,725,313.38
NON-COVERD CHARGES	618,250.21	TOTAL MEDICAID LIAB	1,882,776.37
		LESS: COB	742.68
		LESS: COPAYMENT	4,574.05
		REIMBURSEMENT	1,877,459.64
		ALL OTHER	1,496,031.61
		FEE SCHEDULE-LAB	126,122.95
		INJECTABLE DRUGS	255,305.08

TOTAL NUMBER OF CLAIMS 3,795

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397,135.15	263.46	OTHER LAB	47,765.96	0.00
MED/SURG SUPPLY	384,439.16	36.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	88.00
RADIOLOGY-DIAGNOSTIC	395,722.00	21,786.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,066,474.00	52,857.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,089.00	8,331.00	FEE SCHEDULE LAB	688,869.08	53,632.57
EKG/ECG	78,208.00	5,500.00	MRI SERVICES	216,789.00	18,482.00
IV THERAPY	207,958.00	50,029.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	846,105.57	60,212.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,050.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,088.31	21,659.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,550.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,582,863.75	66,694.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	462,992.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,650.21	224,676.57
RADIOLOGY THERAPEUTIC	57,629.49	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,795.00	807.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,765.00	1,097.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,896.00	1,303.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,248.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	177,702.39	3,101.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,104.00	1,116.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,029.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	69,438.00	11,712.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,040.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	130,693.59	14,867.00			

TOTAL ANCILLARY	8,608,089.75	618,250.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,608,089.75	618,250.21

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,117.95	ADJUSTMENTS	0.00
COVERED CHARGES	79,050.37	CONTRACTUAL ALLOW	22,946.77
NON-COVERD CHARGES	31,067.58	TOTAL MEDICAID LIAB	56,103.60
		LESS: COB	56,083.14
		LESS: COPAYMENT	20.46
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,399.36	737.40	OTHER LAB	850.00	0.00
MED/SURG SUPPLY	2,129.23	3,824.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	962.00	1,280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,005.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,172.51	610.00
EKG/ECG	660.00	220.00	MRI SERVICES	2,533.00	0.00
IV THERAPY	6,513.00	1,012.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,323.50	7,988.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,251.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,430.75	1,480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,994.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,962.02	2,450.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	868.74
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,379.00	1,464.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,916.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	9,132.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,838.00	0.00			

TOTAL ANCILLARY	79,050.37	31,067.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,050.37	31,067.58

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,029.08	ADJUSTMENTS	692.06
COVERED CHARGES	159,834.93	CONTRACTUAL ALLOW	150,336.29
NON-COVERD CHARGES	5,194.15	TOTAL MEDICAID LIAB	9,498.64
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	9,183.64
		TOTAL NUMBER OF CLAIMS	167

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,275.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,825.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,591.00	666.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,378.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,161.00	898.00
EKG/ECG	880.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	420.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	282.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,462.50	740.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,308.68	2,713.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	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	0.00	177.00			

TOTAL ANCILLARY	159,834.93	5,194.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,834.93	5,194.15

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,227.25	ADJUSTMENTS	0.00
COVERED CHARGES	3,238.25	CONTRACTUAL ALLOW	1,003.03
NON-COVERD CHARGES	3,989.00	TOTAL MEDICAID LIAB	2,235.22
		LESS: COB	2,235.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	483.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,962.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	125.00	27.00
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	1,461.00	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	705.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,238.25	3,989.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,238.25	3,989.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,672,602.62	ADJUSTMENTS	92,020.84
COVERED CHARGES	1,614,123.98	CONTRACTUAL ALLOW	1,256,870.64
NON-COVERD CHARGES	58,478.64	TOTAL MEDICAID LIAB	357,253.34
		LESS: COB	2,845.61
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	354,191.73

TOTAL NUMBER OF CLAIMS 62

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,289.70	373.15	OTHER LAB	1,280.00	0.00
MED/SURG SUPPLY	57,892.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,890.00	2,657.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	502.00	FEE SCHEDULE LAB	13,401.00	552.00
EKG/ECG	220.00	440.00	MRI SERVICES	0.00	4,007.00
IV THERAPY	35,900.00	4,538.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,241.00	3,358.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	480.00	292.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,134.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,246.00	2,011.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,981.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,243,188.66	37,798.01
RADIOLOGY THERAPEUTIC	64,032.89	495.54	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	276.00	76.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,656.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	387.00	558.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,628.00	820.00			

TOTAL ANCILLARY	1,614,123.98	58,478.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,614,123.98	58,478.64

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,550,910.53	ADJUSTMENTS	469,014.83
COVERED CHARGES	29,976,786.53	CONTRACTUAL ALLOW	19,578,289.99
NON-COVERD CHARGES	2,574,124.00	TOTAL MEDICAID LIAB	10,398,496.54
		LESS: COB	93,842.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,304,653.88

TOTAL NUMBER OF ADMISSIONS 1,137

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,237	0	4,094,016.00	2,308,103.00
ROUTINE NURSERY	65	0	42,493.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,302	0	4,136,509.00	2,308,103.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	981	0	1,680,704.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	981	0	1,680,704.00	0.00
TOTAL ACCOMODATIONS	7,283	0	5,817,213.00	2,308,103.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,489,872.76	8,168.00	OTHER LAB	52,113.00	0.00
MED/SURG SUPPLY	2,056,428.99	12,083.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,898,555.00	14,778.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	438,467.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361,478.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	255,893.82	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	81,068.00	0.00	MRI SERVICES	257,393.00	0.00
IV THERAPY	193,540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,210,553.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	86,360.00	97.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,106,466.00	9,278.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	148,288.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	128,288.00	1,399.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,164,033.00	3,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	184,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	95,612.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	363,200.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	160,065.99	132.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	70,217.97	115.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	220,330.00	5,562.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	10,991.00	TRAUMA RESPONSE	0.00	8,928.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,670,934.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,278.00	5,240.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	333,424.00	185,849.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	83,777.00	0.00			
AUDIOLOGY	12,750.00	0.00			
CARDIOLOGY	851,888.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,716.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,573.00	110.00			

TOTAL ANCILLARY	24,159,573.53	266,021.00
TOTAL ACCOMODATIONS	5,817,213.00	2,308,103.00
TOTAL CHARGES	29,976,786.53	2,574,124.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,686.03	ADJUSTMENTS	0.00
COVERED CHARGES	40,587.03	CONTRACTUAL ALLOW	24,273.67
NON-COVERD CHARGES	4,099.00	TOTAL MEDICAID LIAB	16,313.36
		LESS: COB	16,313.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	5,760.00	4,099.00
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	5,760.00	4,099.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,608.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	3,608.00	0.00
TOTAL ACCOMODATIONS	11	0	9,368.00	4,099.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,703.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,492.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,102.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	674.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,644.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	214.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,109.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,095.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,428.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	149.00	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	150.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	459.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,219.03	0.00
TOTAL ACCOMODATIONS	9,368.00	4,099.00
TOTAL CHARGES	40,587.03	4,099.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,184,398.51	ADJUSTMENTS	613,902.01
COVERED CHARGES	15,454,894.62	CONTRACTUAL ALLOW	12,184,996.01
NON-COVERD CHARGES	1,729,503.89	TOTAL MEDICAID LIAB	3,269,898.61
		LESS: COB	5,286.05
		LESS: COPAYMENT	14,244.98
		REIMBURSEMENT	3,250,367.58
		ALL OTHER	2,422,492.96
		FEE SCHEDULE-LAB	288,776.16
		INJECTABLE DRUGS	539,098.46

TOTAL NUMBER OF CLAIMS 8,565

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331,693.12	19,516.00	OTHER LAB	85,288.00	0.00
MED/SURG SUPPLY	805,408.00	3,149.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	531,781.00	30,443.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,463,646.00	169,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,281.00	21,582.36	FEE SCHEDULE LAB	2,077,713.90	158,538.20
EKG/ECG	83,857.00	235.00	MRI SERVICES	452,715.00	23,577.00
IV THERAPY	133,758.00	35,530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,191,139.36	253,604.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,490.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	110,713.00	37,888.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,919.00	260.00	AMBULANCE	0.00	0.00
GI SERVICES	312,077.45	58,026.55	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,626,763.21	34,126.59	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	224,464.00	4,216.00	DRUG-SPECIFIC/HOME IV	0.00	5,500.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,197,816.58	606,988.34
RADIOLOGY THERAPEUTIC	1,055,397.00	3,230.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,088.00	11,382.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,028.00	5,130.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	390,092.00	9,486.00	TRAUMA RESPONSE	0.00	12,078.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	261,748.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	362,018.00	29,309.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,075.00	43,272.00			
ONCOLOGY	25,160.00	0.00			
NUCLEAR MEDICINE	308,038.00	40,986.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	505,806.00	64,458.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	204,870.00	340.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	433,051.00	47,452.00			

TOTAL ANCILLARY	15,454,894.62	1,729,503.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,454,894.62	1,729,503.89

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	98,431.00	ADJUSTMENTS	0.00
COVERED CHARGES	69,204.00	CONTRACTUAL ALLOW	13,391.79
NON-COVERD CHARGES	29,227.00	TOTAL MEDICAID LIAB	55,812.21
		LESS: COB	55,748.44
		LESS: COPAYMENT	63.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,214.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,418.00	455.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,802.00	1,222.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,983.00	140.00	FEE SCHEDULE LAB	9,898.00	1,243.00
EKG/ECG	214.00	107.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,691.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303.00	197.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,959.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,811.00	163.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,535.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,454.00	7,817.00
RADIOLOGY THERAPEUTIC	1,685.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,782.00	97.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	912.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	224.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	629.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,401.00	12,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,834.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,399.00	0.00			

TOTAL ANCILLARY	69,204.00	29,227.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,204.00	29,227.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	225,367.00	ADJUSTMENTS	4,142.26
COVERED CHARGES	214,319.00	CONTRACTUAL ALLOW	199,852.68
NON-COVERD CHARGES	11,048.00	TOTAL MEDICAID LIAB	14,466.32
		LESS: COB	31.21
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	14,123.11

TOTAL NUMBER OF CLAIMS 235

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,935.00	25.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,298.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,967.00	2,226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,362.00	6,871.00
EKG/ECG	963.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,938.00	272.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,265.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,169.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	290.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,852.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,493.00	1,577.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	77.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,360.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,579.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	214,319.00	11,048.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	214,319.00	11,048.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,394.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,230.00	CONTRACTUAL ALLOW	3,913.37
NON-COVERD CHARGES	164.00	TOTAL MEDICAID LIAB	3,316.63
		LESS: COB	3,307.63
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	449.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,006.00	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	1,000.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,057.00	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	202.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,358.00	136.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	158.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,230.00	164.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,230.00	164.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,025,594.41	ADJUSTMENTS	117,491.64
COVERED CHARGES	4,671,248.52	CONTRACTUAL ALLOW	3,882,684.45
NON-COVERD CHARGES	354,345.89	TOTAL MEDICAID LIAB	788,564.07
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	788,000.07

TOTAL NUMBER OF CLAIMS 141

GEORGIA 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,101.00	6,189.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	368,810.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,677.00	40,235.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,218.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,496.07	FEE SCHEDULE LAB	32,612.00	4,864.00
EKG/ECG	2,782.00	154.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,767.00	1,224.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	494,881.70	148,760.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,535.00	1,113.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,852.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,084,310.32	53,899.50
RADIOLOGY THERAPEUTIC	486,532.00	6,768.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	312.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,901.00	442.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	673,927.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	121.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	1,205.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	335,289.00	82,603.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,209.00	5,081.00			

TOTAL ANCILLARY	4,671,248.52	354,345.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,671,248.52	354,345.89

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	62,263.00	ADJUSTMENTS	0.00
COVERED CHARGES	62,173.00	CONTRACTUAL ALLOW	6,565.66
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	55,607.34
		LESS: COB	55,592.34
		LESS: COPAYMENT	15.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,100.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	419.00	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	1,093.00	90.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	48,362.00	0.00
RADIOLOGY THERAPEUTIC	7,290.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,909.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	62,173.00	90.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,173.00	90.00

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,173,133.41	ADJUSTMENTS	1,019,789.14
COVERED CHARGES	77,870,895.71	CONTRACTUAL ALLOW	58,561,306.88
NON-COVERD CHARGES	1,302,237.70	TOTAL MEDICAID LIAB	19,309,588.83
		LESS: COB	89,461.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,220,127.39

TOTAL NUMBER OF ADMISSIONS 2,031

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,225	0	10,369,189.00	524,394.00
ROUTINE NURSERY	844	0	1,453,939.00	296,379.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	55.00
TOTAL ROUTINE	8,069	0	11,823,128.00	820,828.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	969	0	3,589,921.00	22,422.00
NICU	273	0	1,031,940.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,242	0	4,621,861.00	22,422.00
TOTAL ACCOMODATIONS	9,311	0	16,444,989.00	843,250.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,215,693.04	15,009.70	OTHER LAB	477,183.00	0.00
MED/SURG SUPPLY	3,572,915.04	27,139.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,783,978.17	20,789.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	995,890.00	810.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,457,845.00	3,291.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	241,233.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,837,478.00	0.00	MRI SERVICES	671,232.00	0.00
IV THERAPY	1,045,466.00	0.00	PROFESSIONAL FEES	0.00	413.00
OPERATING ROOM	6,979,627.00	43,826.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,833,733.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,657,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	281,156.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	534,914.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,632,719.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	417,354.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	554,621.47	0.00	INJECTABLE DRUGS	1,268,716.80	0.00
RADIOLOGY THERAPEUTIC	147,829.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	140,087.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	106,564.27	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	614,120.00	6,484.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,641.00	14,347.00	TRAUMA RESPONSE	0.00	151,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,279,429.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	32,102.00
OTHER IMAGING SERVICE	504,984.00	18,472.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	469,281.00	80,262.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	382,820.00	44,143.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,875,477.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,251.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	329,419.55	0.00			

TOTAL ANCILLARY	61,425,906.71	458,987.70
TOTAL ACCOMODATIONS	16,444,989.00	843,250.00
TOTAL CHARGES	77,870,895.71	1,302,237.70

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 07/01/17 THROUGH 06/30/18
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	2017223069989	07/27/17 - 07/30/17	08/14/17	0.00	1,387.00	0.00	0.00	0.00
615	2017242062025	08/20/17 - 08/23/17	09/04/17	0.00	1,387.00	0.00	0.00	0.00
615	2017251085051	08/23/17 - 08/29/17	09/11/17	0.00	1,387.00	0.00	0.00	0.00
615	2017270070563	09/15/17 - 09/19/17	10/02/17	0.00	1,387.00	0.00	0.00	0.00
615	2017285069837	09/30/17 - 10/04/17	10/16/17	0.00	1,387.00	0.00	0.00	0.00
615	2017356064997	11/28/17 - 12/15/17	01/01/18	0.00	1,387.00	0.00	0.00	0.00
615	2018011081933	12/22/17 - 01/03/18	01/15/18	0.00	1,387.00	0.00	0.00	0.00
615	2018019061575	12/18/17 - 12/21/17	01/22/18	0.00	1,387.00	0.00	0.00	0.00
615	2018025090674	09/04/17 - 09/06/17	01/29/18	0.00	1,387.00	0.00	0.00	0.00
615	2018036028920	01/15/18 - 01/17/18	02/12/18	0.00	1,387.00	0.00	0.00	0.00
618	2018039080960	12/07/17 - 12/22/17	02/12/18	0.00	1,588.00	0.00	0.00	0.00
615	2018057038906	10/09/17 - 10/17/17	03/05/18	0.00	1,387.00	0.00	0.00	0.00
615	2018089049129	03/24/18 - 03/25/18	04/02/18	0.00	1,387.00	0.00	0.00	0.00
615	2018092028232	02/28/18 - 03/04/18	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018092028263	03/12/18 - 03/13/18	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018093083764	09/08/17 - 09/18/17	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018141028188	05/07/18 - 05/08/18	05/28/18	0.00	1,387.00	0.00	0.00	0.00
615	2018143061057	05/10/18 - 05/15/18	05/28/18	0.00	1,387.00	0.00	0.00	0.00
615	2018152080836	05/12/18 - 05/14/18	06/04/18	0.00	1,387.00	0.00	0.00	0.00
615	2018163059588	05/31/18 - 06/06/18	06/18/18	0.00	1,387.00	0.00	0.00	0.00
615	2018228087222	01/25/18 - 02/09/18	08/20/18	0.00	1,387.00	0.00	0.00	0.00
615	2019053080964	07/23/17 - 08/01/17	02/25/19	0.00	1,387.00	0.00	0.00	0.00
615	2019172065431	02/22/18 - 02/24/18	06/24/19	0.00	1,387.00	0.00	0.00	0.00
TOTAL				0.00	32,102.00	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,079,620.48	ADJUSTMENTS	0.00
COVERED CHARGES	1,046,840.48	CONTRACTUAL ALLOW	464,049.91
NON-COVERD CHARGES	32,780.00	TOTAL MEDICAID LIAB	582,790.57
		LESS: COB	582,790.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	62	0	86,345.00	4,307.00
ROUTINE NURSERY	60	0	153,918.00	26,552.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	122	0	240,263.00	30,859.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	11	0	41,107.00	0.00
NICU	50	0	189,000.00	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	61	0	230,107.00	0.00
TOTAL ACCOMODATIONS	183	0	470,370.00	30,859.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179,268.74	0.00	OTHER LAB	3,467.00	0.00
MED/SURG SUPPLY	54,387.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	114,205.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,758.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,522.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,610.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,690.00	0.00	MRI SERVICES	2,112.00	0.00
IV THERAPY	9,535.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,866.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,525.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,435.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,520.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,715.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,223.00	0.00	INJECTABLE DRUGS	3,444.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,103.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,231.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	79.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,767.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,387.00
OTHER IMAGING SERVICE	6,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	976.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,936.00	534.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,268.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	576,470.48	1,921.00
TOTAL ACCOMODATIONS	470,370.00	30,859.00
TOTAL CHARGES	1,046,840.48	32,780.00

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 07/01/17 THROUGH 06/30/18
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	2218117013285	11/18/17 - 12/01/17	04/30/18	0.00	1,387.00	0.00	47,906.54	0.00
TOTAL				0.00	1,387.00	0.00	47,906.54	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,197,500.44	ADJUSTMENTS	1,557,647.75
COVERED CHARGES	32,210,487.55	CONTRACTUAL ALLOW	27,130,989.18
NON-COVERD CHARGES	1,987,012.89	TOTAL MEDICAID LIAB	5,079,498.37
		LESS: COB	40,585.28
		LESS: COPAYMENT	12,881.39
		REIMBURSEMENT	5,026,031.70
		ALL OTHER	4,104,741.47
		FEE SCHEDULE-LAB	511,143.78
		INJECTABLE DRUGS	410,146.45

TOTAL NUMBER OF CLAIMS 11,464

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	521,453.91	0.00	OTHER LAB	353,531.00	1,003.00
MED/SURG SUPPLY	874,434.51	6,509.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,098,883.50	12,882.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,087,383.00	84,810.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,657.00	20,327.00	FEE SCHEDULE LAB	4,566,506.96	278,861.77
EKG/ECG	454,789.00	4,607.00	MRI SERVICES	936,449.00	35,917.00
IV THERAPY	1,514,120.00	135,695.00	PROFESSIONAL FEES	0.00	56.00
OPERATING ROOM	2,569,792.00	165,099.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	166,031.00	34,634.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,230.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	218,936.00	36,759.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,719,935.00	9,737.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	273,833.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,086,155.97	353,328.65
RADIOLOGY THERAPEUTIC	311,310.00	113,603.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,538.00	3,141.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,078.00	4,962.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	210,868.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	151,680.00	23,056.00	TRAUMA RESPONSE	0.00	174,685.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	234,559.38	34,007.17
LITHOTRIPSY	83,908.00	0.00	NO CC/INVALID REV CODE	0.00	1,387.00
OTHER IMAGING SERVICE	1,458,354.00	58,542.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	148,882.00	1,386.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	670,564.00	80,397.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	853,337.00	98,506.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	411,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,240,266.17	2,246.00			

TOTAL ANCILLARY	32,210,487.55	1,987,012.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,210,487.55	1,987,012.89

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 07/01/17 THROUGH 06/30/18
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	2018151084339	04/29/18 - 04/29/18	06/11/18	0.00	1,387.00	0.00	0.00	0.00
TOTAL				0.00	1,387.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	369,967.93	ADJUSTMENTS	0.00
COVERED CHARGES	294,601.58	CONTRACTUAL ALLOW	172,568.19
NON-COVERD CHARGES	75,366.35	TOTAL MEDICAID LIAB	122,033.39
		LESS: COB	121,940.52
		LESS: COPAYMENT	92.87
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,987.23	0.00	OTHER LAB	4,737.00	0.00
MED/SURG SUPPLY	5,689.35	917.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,355.00	3,544.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,359.00	2,547.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,296.00	FEE SCHEDULE LAB	39,304.90	2,456.84
EKG/ECG	5,317.00	0.00	MRI SERVICES	0.00	2,973.00
IV THERAPY	19,334.00	2,150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,256.00	36,362.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,888.00	394.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,875.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,547.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,089.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,917.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,631.77	1,313.35
RADIOLOGY THERAPEUTIC	600.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	994.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,367.00	318.00	TRAUMA RESPONSE	0.00	7,595.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52.18	1,399.99
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,752.00	1,500.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,938.00	6,093.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,039.00	1,966.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,113.15	0.00			

TOTAL ANCILLARY	294,601.58	75,366.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	294,601.58	75,366.35

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	702,922.95	ADJUSTMENTS	712.22
COVERED CHARGES	689,387.23	CONTRACTUAL ALLOW	668,689.43
NON-COVERD CHARGES	13,535.72	TOTAL MEDICAID LIAB	20,697.80
		LESS: COB	0.00
		LESS: COPAYMENT	525.00
		REIMBURSEMENT	20,172.80
		TOTAL NUMBER OF CLAIMS	370

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,517.25	0.00	OTHER LAB	4,196.00	0.00
MED/SURG SUPPLY	10,314.98	340.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,116.00	6,730.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,060.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	102,540.30	4,651.72
EKG/ECG	6,030.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,426.00	645.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,389.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,566.00	181.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	412,435.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,767.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,443.25	778.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	210.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	260.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,966.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,087.45	0.00			

TOTAL ANCILLARY	689,387.23	13,535.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	689,387.23	13,535.72

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,788.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,307.00	CONTRACTUAL ALLOW	1,167.91
NON-COVERD CHARGES	481.00	TOTAL MEDICAID LIAB	3,139.09
		LESS: COB	3,136.09
		LESS: COPAYMENT	3.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	481.00	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	336.00	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	3,676.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,307.00	481.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,307.00	481.00

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

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,111,089.28	ADJUSTMENTS	179,649.01
COVERED CHARGES	3,874,146.44	CONTRACTUAL ALLOW	3,249,203.93
NON-COVERD CHARGES	236,942.84	TOTAL MEDICAID LIAB	624,942.51
		LESS: COB	0.00
		LESS: COPAYMENT	978.20
		REIMBURSEMENT	623,964.31
		TOTAL NUMBER OF CLAIMS	111

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,189.60	0.00	OTHER LAB	1,292.00	0.00
MED/SURG SUPPLY	330,318.83	896.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,962.00	389.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,662.00	1,880.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	140,729.08	3,188.44
EKG/ECG	7,705.00	9,670.00	MRI SERVICES	5,938.00	0.00
IV THERAPY	237,433.00	3,655.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	519,493.00	770.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,052.00	2,493.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,023.00	362.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,858.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,357,745.02	42,069.40
RADIOLOGY THERAPEUTIC	4,917.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,033.00	4,909.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	693,663.91	13,408.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,622.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,556.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	313,924.00	153,253.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,790.00	0.00			

TOTAL ANCILLARY	3,874,146.44	236,942.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,874,146.44	236,942.84

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,641,912.99	ADJUSTMENTS	21,399.53
COVERED CHARGES	3,618,801.02	CONTRACTUAL ALLOW	1,960,582.71
NON-COVERD CHARGES	23,111.97	TOTAL MEDICAID LIAB	1,658,218.31
		LESS: COB	41,475.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,616,742.35

TOTAL NUMBER OF ADMISSIONS 224

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	522	0	383,978.43	8,776.22
ROUTINE NURSERY	54	0	34,527.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	576	0	418,505.93	8,776.22
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	330	0	452,687.84	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	330	0	452,687.84	0.00
TOTAL ACCOMODATIONS	906	0	871,193.77	8,776.22

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,580.89	0.00	OTHER LAB	24,402.73	0.00
MED/SURG SUPPLY	234,957.07	157.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	597,539.69	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,376.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	211,534.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,051.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,851.98	0.00	MRI SERVICES	26,654.92	0.00
IV THERAPY	29,714.51	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,963.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,991.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144,816.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	571.23	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	139,242.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,627.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	686.33	0.00	INJECTABLE DRUGS	603,366.38	0.00
RADIOLOGY THERAPEUTIC	15,999.89	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,671.47	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,821.97	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	19,648.20	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	773.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,360.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,711.32
OTHER IMAGING SERVICE	17,543.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,887.76	12,467.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,271.87	0.00			
AUDIOLOGY	2,188.90	0.00			
CARDIOLOGY	81,172.23	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,482.66	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	855.64	0.00			

TOTAL ANCILLARY	2,747,607.25	14,335.75
TOTAL ACCOMODATIONS	871,193.77	8,776.22
TOTAL CHARGES	3,618,801.02	23,111.97

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2018169008705	06/10/18 - 06/10/18	06/25/18	0.00	1,711.32	0.00	0.00	0.00
TOTAL				0.00	1,711.32	0.00	0.00	0.00

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,267.31	ADJUSTMENTS	0.00
COVERED CHARGES	6,266.92	CONTRACTUAL ALLOW	1,253.07
NON-COVERD CHARGES	0.39	TOTAL MEDICAID LIAB	5,013.85
		LESS: COB	5,013.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	2,211.00	0.39
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	2,211.00	0.39
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	2,211.00	0.39

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	596.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	341.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	351.23	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,441.48	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	325.86	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,055.92	0.00
TOTAL ACCOMODATIONS	2,211.00	0.39
TOTAL CHARGES	6,266.92	0.39

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,006,077.19	ADJUSTMENTS	210,532.12
COVERED CHARGES	4,482,073.40	CONTRACTUAL ALLOW	3,496,966.12
NON-COVERD CHARGES	524,003.79	TOTAL MEDICAID LIAB	985,107.28
		LESS: COB	2,575.27
		LESS: COPAYMENT	2,947.88
		REIMBURSEMENT	979,584.13
		ALL OTHER	771,787.92
		FEE SCHEDULE-LAB	164,677.39
		INJECTABLE DRUGS	43,118.82

TOTAL NUMBER OF CLAIMS 3,524

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,953.54	749.46	OTHER LAB	28,166.59	811.71
MED/SURG SUPPLY	130,792.85	3,924.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	122.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186,264.35	3,229.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	702,932.03	86,099.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,861.79	5,186.74	FEE SCHEDULE LAB	982,398.88	58,711.28
EKG/ECG	43,439.80	1,120.77	MRI SERVICES	55,759.79	2,724.50
IV THERAPY	77,197.27	9,556.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,035.68	8,032.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,157.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,429.90	4,874.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	326.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	102,005.17	2,926.62	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,014,501.86	23,916.53	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,117.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	197,676.42	34,642.51
RADIOLOGY THERAPEUTIC	335,464.76	196,770.39	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,199.94	1,742.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,955.68	1,083.62	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	542.58	1,649.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,759.97	185.88
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	95,330.35	10,231.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,070.69	13,501.91			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	106,182.75	43,210.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,259.72	2,995.15			
AMBULATORY SURGERY	197.60	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,462.61	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,629.25	6,005.05			

TOTAL ANCILLARY	4,482,073.40	524,003.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,482,073.40	524,003.79

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,920.08	ADJUSTMENTS	0.00
COVERED CHARGES	21,502.02	CONTRACTUAL ALLOW	10,855.13
NON-COVERD CHARGES	3,418.06	TOTAL MEDICAID LIAB	10,646.89
		LESS: COB	10,631.89
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.45	22.88	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	536.13	64.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	774.14	617.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,009.90	1,181.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,341.94	217.37
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,150.61	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,066.18	41.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	329.33	194.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	328.85	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	747.53	1,078.85			
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	2,852.99	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	145.00	0.00			

TOTAL ANCILLARY	21,502.02	3,418.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,502.02	3,418.06

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	185,117.27	ADJUSTMENTS	5,810.15
COVERED CHARGES	180,014.36	CONTRACTUAL ALLOW	162,227.89
NON-COVERD CHARGES	5,102.91	TOTAL MEDICAID LIAB	17,786.47
		LESS: COB	30.00
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	17,324.47

TOTAL NUMBER OF CLAIMS 285

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	970.54	62.31	OTHER LAB	404.77	0.00
MED/SURG SUPPLY	1,263.86	26.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,438.98	1,330.33	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,789.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,903.92	1,969.22
EKG/ECG	2,059.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,017.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,392.27	893.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,586.24	25.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,135.60	795.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	180,014.36	5,102.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,014.36	5,102.91

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,472.12	ADJUSTMENTS	5,477.05
COVERED CHARGES	59,046.16	CONTRACTUAL ALLOW	42,615.01
NON-COVERD CHARGES	20,425.96	TOTAL MEDICAID LIAB	16,431.15
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	16,428.15

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	122.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,084.16	19,124.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	900.86	0.00
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	205.85	205.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	755.66	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,723.12	0.00
RADIOLOGY THERAPEUTIC	25,627.69	1,095.83	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	398.46	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	0.00	0.00			

TOTAL ANCILLARY	59,046.16	20,425.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,046.16	20,425.96

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	761,418.75	ADJUSTMENTS	0.00
COVERED CHARGES	657,478.73	CONTRACTUAL ALLOW	407,291.11
NON-COVERD CHARGES	103,940.02	TOTAL MEDICAID LIAB	250,187.62
		LESS: COB	320.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	249,866.73

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	188	0	112,800.00	101,229.00
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	188	0	112,800.00	101,229.00
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	188	0	112,800.00	101,229.00

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,248.70	0.00	OTHER LAB	3,501.00	0.00
MED/SURG SUPPLY	32,189.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	82,951.16	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,983.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,166.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,336.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,321.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,263.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,485.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,672.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,304.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,827.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,160.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	169.54	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	285.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	534.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	72,287.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,579.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,125.76	1,437.42			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,467.00	1,273.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,661.86	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,161.00	0.00			

TOTAL ANCILLARY	544,678.73	2,711.02
TOTAL ACCOMODATIONS	112,800.00	101,229.00
TOTAL CHARGES	657,478.73	103,940.02

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,827,722.64	ADJUSTMENTS	69,032.34
COVERED CHARGES	1,586,710.62	CONTRACTUAL ALLOW	1,290,095.18
NON-COVERD CHARGES	241,012.02	TOTAL MEDICAID LIAB	296,615.44
		LESS: COB	166.40
		LESS: COPAYMENT	1,032.00
		REIMBURSEMENT	295,417.04
		ALL OTHER	240,391.63
		FEE SCHEDULE-LAB	52,972.32
		INJECTABLE DRUGS	2,053.09

TOTAL NUMBER OF CLAIMS 1,647

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,080.04	6,948.47	OTHER LAB	6,618.00	0.00
MED/SURG SUPPLY	28,776.43	2,936.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,444.78	7,290.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,275.00	13,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,019.35	1,430.22	FEE SCHEDULE LAB	416,015.44	75,024.76
EKG/ECG	18,189.00	1,161.00	MRI SERVICES	38,134.00	0.00
IV THERAPY	80,475.21	19,938.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,047.50	2,084.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,773.00	5,955.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,832.00	1,281.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	457,867.92	12,165.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,080.00	5,680.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,726.32	11,161.31
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	328.29	0.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,775.31	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	640.00	48,367.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,752.56	6,652.41			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,648.00	11,034.16			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,256.78	5,584.62			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,731.00	1,398.00			

TOTAL ANCILLARY	1,586,710.62	241,012.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,586,710.62	241,012.02

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,233.40	ADJUSTMENTS	0.00
COVERED CHARGES	5,753.36	CONTRACTUAL ALLOW	3,368.78
NON-COVERD CHARGES	1,480.04	TOTAL MEDICAID LIAB	2,384.58
		LESS: COB	2,384.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70.38	63.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	148.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,200.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,124.58	36.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	153.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,283.69	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.99	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,753.36	1,480.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,753.36	1,480.04

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,346.08	ADJUSTMENTS	3,684.03
COVERED CHARGES	177,768.08	CONTRACTUAL ALLOW	168,493.06
NON-COVERD CHARGES	5,578.00	TOTAL MEDICAID LIAB	9,275.02
		LESS: COB	0.00
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	8,978.02
		TOTAL NUMBER OF CLAIMS	149

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,184.05	362.82	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	352.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,168.24	186.36	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,095.00	1,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,481.72	1,070.82
EKG/ECG	774.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,412.01	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,007.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	106,011.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,890.72	313.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,392.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,768.08	5,578.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,768.08	5,578.00

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,052.97	ADJUSTMENTS	12,179.44
COVERED CHARGES	113,150.97	CONTRACTUAL ALLOW	71,950.30
NON-COVERD CHARGES	1,902.00	TOTAL MEDICAID LIAB	41,200.67
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	41,200.67

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	26	0	20,692.00	1,902.00
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	20,692.00	1,902.00
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	20,692.00	1,902.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,927.25	0.00	OTHER LAB	499.00	0.00
MED/SURG SUPPLY	713.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,589.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,594.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,788.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	950.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,827.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,950.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,086.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,535.00	0.00			

TOTAL ANCILLARY	92,458.97	0.00
TOTAL ACCOMODATIONS	20,692.00	1,902.00
TOTAL CHARGES	113,150.97	1,902.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	785,239.53	ADJUSTMENTS	59,869.53
COVERED CHARGES	676,216.85	CONTRACTUAL ALLOW	466,395.98
NON-COVERD CHARGES	109,022.68	TOTAL MEDICAID LIAB	209,820.87
		LESS: COB	616.53
		LESS: COPAYMENT	402.00
		REIMBURSEMENT	208,802.34
		ALL OTHER	191,418.82
		FEE SCHEDULE-LAB	16,320.18
		INJECTABLE DRUGS	1,063.34

TOTAL NUMBER OF CLAIMS 813

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,088.72	931.25	OTHER LAB	3,295.00	0.00
MED/SURG SUPPLY	838.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,811.50	6,323.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,551.00	60,153.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,126.75	15,116.50
EKG/ECG	9,570.00	760.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,489.00	1,413.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	338.00	530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291,385.50	5,444.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,555.12	13,205.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,347.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,076.50	2,242.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,447.00	1,447.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,644.00	109.00			

TOTAL ANCILLARY	676,216.85	109,022.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	676,216.85	109,022.68

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	915.00	ADJUSTMENTS	0.00
COVERED CHARGES	689.00	CONTRACTUAL ALLOW	200.06
NON-COVERD CHARGES	226.00	TOTAL MEDICAID LIAB	488.94
		LESS: COB	488.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	689.00	226.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	689.00	226.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	689.00	226.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,964.90	ADJUSTMENTS	815.14
COVERED CHARGES	26,875.40	CONTRACTUAL ALLOW	23,205.68
NON-COVERD CHARGES	1,089.50	TOTAL MEDICAID LIAB	3,669.72
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	3,564.72
		TOTAL NUMBER OF CLAIMS	60

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397.15	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	978.00	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	4,281.00	1,006.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	574.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	20,452.00	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	193.25	83.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,875.40	1,089.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,875.40	1,089.50

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	722.25	ADJUSTMENTS	0.00
COVERED CHARGES	722.25	CONTRACTUAL ALLOW	267.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	454.38
		LESS: COB	451.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	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	538.00	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	161.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	722.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	722.25	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EAST 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,761,983.58	ADJUSTMENTS	300,683.85
COVERED CHARGES	33,960,897.05	CONTRACTUAL ALLOW	27,636,535.11
NON-COVERD CHARGES	801,086.53	TOTAL MEDICAID LIAB	6,324,361.94
		LESS: COB	37,644.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,286,717.77

TOTAL NUMBER OF ADMISSIONS 690

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	966	0	655,907.00	516,776.00
ROUTINE NURSERY	238	0	176,308.00	138,267.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,204	0	832,215.00	655,043.00
SPECIAL CARE SERVICES				
CCU	336	0	632,628.00	0.00
ICU	1,604	0	2,757,716.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,940	0	3,390,344.00	0.00
TOTAL ACCOMODATIONS	3,144	0	4,222,559.00	655,043.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,306,281.55	0.00	OTHER LAB	95,311.79	0.00
MED/SURG SUPPLY	1,200,719.76	620.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,191,398.58	0.00	EDUCATION & TRAINING	7,014.56	0.00
RADIOLOGY-DIAGNOSTIC	819,241.40	3,768.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,652,186.49	11,934.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	313,764.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	124,757.17	0.00	MRI SERVICES	270,349.18	0.00
IV THERAPY	170.72	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,416,725.66	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	416,651.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,841,621.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	714,020.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	332,981.81	9,860.59	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,263,774.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	232,993.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	220,590.68	0.00	INJECTABLE DRUGS	2,602,563.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,424.17	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,876.46	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	131,210.23	1,233.27	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,540.47	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,440,296.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	56,236.56
OTHER IMAGING SERVICE	127,514.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	157,771.48	53,882.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,892.03	8,508.48			
AUDIOLOGY	41,956.15	0.00			
CARDIOLOGY	1,559,431.93	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,444.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94,861.22	0.00			

TOTAL ANCILLARY	29,738,338.05	146,043.53
TOTAL ACCOMODATIONS	4,222,559.00	655,043.00
TOTAL CHARGES	33,960,897.05	801,086.53

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 10/01/17 THROUGH 09/30/18
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	5018023957033	12/21/17 - 12/24/17	01/29/18	0.00	1,817.34	0.00	0.00	0.00
615	2018052022847	02/09/18 - 02/10/18	02/26/18	0.00	3,522.36	0.00	0.00	0.00
615	2018057024288	02/11/18 - 02/19/18	03/05/18	0.00	3,522.36	0.00	0.00	0.00
615	2018079042137	10/04/17 - 10/06/17	03/26/18	0.00	3,522.36	0.00	0.00	0.00
615	2018093067720	03/20/18 - 03/22/18	04/09/18	0.00	3,522.36	0.00	0.00	0.00
615	2018142060119	05/08/18 - 05/17/18	05/28/18	0.00	8,254.00	0.00	0.00	0.00
615	2218151006155	02/15/18 - 02/20/18	06/04/18	0.00	3,522.36	0.00	0.00	0.00
615	2018162009261	06/01/18 - 06/02/18	06/18/18	0.00	8,254.00	0.00	0.00	0.00
614	2218187011507	03/10/18 - 03/22/18	07/09/18	0.00	1,833.06	0.00	0.00	0.00
615	2018199041694	07/12/18 - 07/13/18	07/23/18	0.00	3,698.00	0.00	0.00	0.00
615	2018247055738	08/27/18 - 08/28/18	09/10/18	0.00	3,698.00	0.00	0.00	0.00
614	2218250007587	07/31/18 - 08/18/18	09/17/18	0.00	3,850.00	0.00	0.00	0.00
615	2018331045781	04/14/18 - 04/20/18	12/03/18	0.00	3,522.36	0.00	0.00	0.00
615	2319122000267	07/16/18 - 07/26/18	05/13/19	0.00	3,698.00	0.00	3,500.74	0.00
TOTAL				0.00	56,236.56	0.00	3,500.74	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,632.90	ADJUSTMENTS	0.00
COVERED CHARGES	85,358.90	CONTRACTUAL ALLOW	61,491.17
NON-COVERD CHARGES	3,274.00	TOTAL MEDICAID LIAB	23,867.73
		LESS: COB	23,867.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	3,972.00	3,274.00
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	3,972.00	3,274.00
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	3,972.00	3,274.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,197.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,464.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,211.68	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	579.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,146.92	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	678.43	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	35,620.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	511.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,061.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,753.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,126.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	308.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	378.53	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,350.92	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	81,386.90	0.00
TOTAL ACCOMODATIONS	3,972.00	3,274.00
TOTAL CHARGES	85,358.90	3,274.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,453,138.67	ADJUSTMENTS	684,115.42
COVERED CHARGES	27,084,253.95	CONTRACTUAL ALLOW	25,167,016.11
NON-COVERD CHARGES	2,368,884.72	TOTAL MEDICAID LIAB	1,917,237.84
		LESS: COB	36,356.59
		LESS: COPAYMENT	4,337.05
		REIMBURSEMENT	1,876,544.20
		ALL OTHER	1,708,481.69
		FEE SCHEDULE-LAB	139,268.19
		INJECTABLE DRUGS	28,794.32

TOTAL NUMBER OF CLAIMS 4,586

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840,223.12	584.88	OTHER LAB	578,638.52	15,826.25
MED/SURG SUPPLY	704,308.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,179.90	EDUCATION & TRAINING	0.00	2,919.21
RADIOLOGY-DIAGNOSTIC	953,705.22	114,570.98	OTHER THERAPEUTIC SVC	0.00	30,554.93
CT SCAN	2,782,217.14	235,662.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	13,365.19	FEE SCHEDULE LAB	3,238,175.86	131,660.49
EKG/ECG	129,904.20	6,612.30	MRI SERVICES	680,542.26	62,164.80
IV THERAPY	18,888.30	10,854.61	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,845,716.38	521,344.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,833.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	346,844.82	92,466.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	696,344.71	10,553.64	AMBULANCE	0.00	0.00
GI SERVICES	890,759.76	111,925.84	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,458,366.48	96,944.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	591,270.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	871,122.07	275,460.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,147.41	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	505.44	6,823.91	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	74,082.55	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	59,711.43	7,895.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	333,816.29	87,014.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,861.28
OTHER IMAGING SERVICE	562,141.41	95,231.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,816.35	7,195.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	149,241.27	44,808.79			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,660,585.30	212,687.72			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,773.92	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	650,801.75	87,484.18			

TOTAL ANCILLARY	27,084,253.95	2,368,884.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,084,253.95	2,368,884.72

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 10/01/17 THROUGH 09/30/18
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	5918052000764	12/27/17 - 12/27/17	02/26/18	0.00	3,522.36	0.00	0.00	0.00
614	5918103000202	03/30/18 - 03/30/18	04/16/18	0.00	4,338.92	0.00	0.00	0.00
TOTAL				0.00	7,861.28	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	556,565.09	ADJUSTMENTS	0.00
COVERED CHARGES	391,465.73	CONTRACTUAL ALLOW	213,103.67
NON-COVERD CHARGES	165,099.36	TOTAL MEDICAID LIAB	178,362.06
		LESS: COB	178,321.74
		LESS: COPAYMENT	40.32
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,230.74	0.00	OTHER LAB	19,339.62	1,344.00
MED/SURG SUPPLY	442.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	73.01
RADIOLOGY-DIAGNOSTIC	14,411.75	1,747.70	OTHER THERAPEUTIC SVC	0.00	3,218.44
CT SCAN	17,705.00	40,694.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,692.26	1,812.60
EKG/ECG	2,275.10	213.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,226.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,515.00	36,732.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,062.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,078.01	1,190.42	AMBULANCE	0.00	0.00
GI SERVICES	0.00	17,036.57	CAST ROOM	0.00	0.00
EMERGENCY ROOM	152,977.47	1,233.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,166.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,153.47	4,178.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	505.47	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,615.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,661.44	16,455.64			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	32,984.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,527.79	2,064.37			

TOTAL ANCILLARY	391,465.73	165,099.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	391,465.73	165,099.36

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,568,380.48	ADJUSTMENTS	10,514.42
COVERED CHARGES	2,512,516.97	CONTRACTUAL ALLOW	2,475,414.72
NON-COVERD CHARGES	55,863.51	TOTAL MEDICAID LIAB	37,102.25
		LESS: COB	93.10
		LESS: COPAYMENT	1,047.00
		REIMBURSEMENT	35,962.15

TOTAL NUMBER OF CLAIMS 635

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,545.13	0.00	OTHER LAB	21,230.33	5,248.90
MED/SURG SUPPLY	28,364.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,121.28	4,144.62	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	255,602.96	10,021.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	295,992.42	9,460.57
EKG/ECG	9,981.50	426.00	MRI SERVICES	5,473.00	0.00
IV THERAPY	1,059.00	282.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,148.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,564.20	1,284.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,353.16	4,762.56	AMBULANCE	0.00	0.00
GI SERVICES	5,075.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,557,656.13	4,744.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,525.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,464.27	3,291.50
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	138.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,807.21	6,708.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,350.92			
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	5,552.76	0.00			

TOTAL ANCILLARY	2,512,516.97	55,863.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,512,516.97	55,863.51

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,857.45	ADJUSTMENTS	0.00
COVERED CHARGES	88,420.32	CONTRACTUAL ALLOW	60,881.71
NON-COVERD CHARGES	9,437.13	TOTAL MEDICAID LIAB	27,538.61
		LESS: COB	27,508.61
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,954.32	325.73	OTHER LAB	5,121.80	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	1,822.95	535.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,504.00	5,416.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,509.65	490.46
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	346.00	385.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	48,926.32	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	3,758.20	71.40
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,477.08	2,212.70			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	88,420.32	9,437.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,420.32	9,437.13

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,316,531.34	ADJUSTMENTS	110,779.29
COVERED CHARGES	2,199,046.98	CONTRACTUAL ALLOW	2,071,506.68
NON-COVERD CHARGES	117,484.36	TOTAL MEDICAID LIAB	127,540.30
		LESS: COB	0.00
		LESS: COPAYMENT	137.32
		REIMBURSEMENT	127,402.98

TOTAL NUMBER OF CLAIMS 23

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,562.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	275,739.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	77.00
RADIOLOGY-DIAGNOSTIC	6,704.38	11,882.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	378.52	4,737.56	FEE SCHEDULE LAB	19,680.47	784.08
EKG/ECG	426.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,547.34	196.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,024,153.50	23,602.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,355.26	7,593.94	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,260.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,040.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200,730.96	9,834.14
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	245.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	280,752.25	58,530.41
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	71,383.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,332.61	0.00			

TOTAL ANCILLARY	2,199,046.98	117,484.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,199,046.98	117,484.36

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,919,592.44	ADJUSTMENTS	1,762,049.74
COVERED CHARGES	94,226,928.02	CONTRACTUAL ALLOW	68,854,176.85
NON-COVERD CHARGES	5,692,664.42	TOTAL MEDICAID LIAB	25,372,751.17
		LESS: COB	416,438.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,956,312.77

TOTAL NUMBER OF ADMISSIONS 3,344

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,828	0	13,394,807.00	4,114,996.00
ROUTINE NURSERY	4,864	0	8,852,473.00	118,986.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,692	0	22,247,280.00	4,233,982.00
SPECIAL CARE SERVICES				
CCU	96	0	419,297.00	0.00
ICU	1,822	0	6,341,589.00	0.00
NICU	189	0	740,776.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	232	0	1,240,040.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,339	0	8,741,702.00	0.00
TOTAL ACCOMODATIONS	16,031	0	30,988,982.00	4,233,982.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,353,754.50	96,039.00	OTHER LAB	716,190.00	1,211.00
MED/SURG SUPPLY	977,397.73	46,094.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,690,041.00	60,754.50	EDUCATION & TRAINING	13,357.00	31.00
RADIOLOGY-DIAGNOSTIC	2,738,957.50	8,932.00	OTHER THERAPEUTIC SVC	5,200.00	0.00
CT SCAN	5,681,124.00	212,419.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	422,920.91	63,002.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	779,584.00	1,756.00	MRI SERVICES	1,017,451.00	9,719.00
IV THERAPY	1,209,826.00	1,490.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,987,002.50	32,242.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,558,490.00	464.00	REHAB THERAPY	572.00	0.00
RESPIRATORY SERVICES	3,679,419.54	25,068.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,005,183.00	4,328.00	AMBULANCE	0.00	0.00
GI SERVICES	393,880.00	1,538.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,524,822.00	5,353.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,628,039.50	6,583.00	DRUG-SPECIFIC/HOME IV	0.00	36,025.00
LABORATORY PATHOLOGIC	509,052.00	0.00	INJECTABLE DRUGS	4,613,699.71	17,213.00
RADIOLOGY THERAPEUTIC	12,317.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195,463.05	37,361.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	143,883.58	9,164.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,111,389.00	194,230.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,336.00	4,751.00	TRAUMA RESPONSE	0.00	245,939.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,598,094.00	832.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	159,924.00
OTHER IMAGING SERVICE	541,942.50	24,599.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	454,153.00	138,766.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	501,369.00	6,650.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,290,587.00	5,496.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	178,090.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	701,358.00	708.00			

TOTAL ANCILLARY	63,237,946.02	1,458,682.42
TOTAL ACCOMODATIONS	30,988,982.00	4,233,982.00
TOTAL CHARGES	94,226,928.02	5,692,664.42

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2017209068361	07/18/17 - 07/21/17	08/07/17	0.00	6,424.00	0.00	0.00	0.00
618	2017209068361	07/18/17 - 07/21/17	08/07/17	0.00	3,249.00	0.00	0.00	0.00
615	2317276000016	08/12/17 - 08/13/17	11/06/17	0.00	4,793.00	0.00	644.79	0.00
615	2017301022426	10/04/17 - 10/19/17	11/06/17	0.00	4,793.00	0.00	0.00	0.00
615	2317303000007	09/16/17 - 09/23/17	12/04/17	0.00	4,793.00	0.00	1,116.82	0.00
615	2317310000036	07/04/17 - 07/06/17	12/04/17	0.00	4,793.00	0.00	0.00	0.00
615	2317310000062	07/10/17 - 07/13/17	12/11/17	0.00	4,793.00	0.00	0.00	0.00
615	2217325003770	10/16/17 - 11/09/17	11/27/17	0.00	4,793.00	0.00	0.00	0.00
615	2317347000011	10/23/17 - 10/25/17	12/25/17	0.00	4,793.00	0.00	647.78	0.00
615	2317353000003	10/17/17 - 10/18/17	01/01/18	0.00	4,793.00	0.00	761.76	0.00
615	2017354003878	07/01/17 - 07/03/17	12/25/17	0.00	4,793.00	0.00	0.00	0.00
615	2217363013521	12/04/17 - 12/12/17	01/01/18	0.00	4,793.00	0.00	0.00	0.00
615	2018008024638	12/29/17 - 12/30/17	01/15/18	0.00	4,793.00	0.00	0.00	0.00
615	2018032061271	01/19/18 - 01/23/18	02/05/18	0.00	4,793.00	0.00	0.00	0.00
615	2318043000051	09/06/17 - 09/08/17	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018045071115	01/14/18 - 01/18/18	02/19/18	0.00	4,793.00	0.00	0.00	0.00
615	2218080009376	02/19/18 - 03/07/18	04/02/18	0.00	2,605.00	0.00	0.00	0.00
615	2318085000140	12/23/17 - 12/27/17	04/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318086000101	01/18/18 - 02/06/18	04/16/18	0.00	4,793.00	0.00	6,393.21	0.00
615	2318094000013	11/16/17 - 12/14/17	04/16/18	0.00	4,793.00	0.00	7,510.67	0.00
615	2318100000085	12/30/17 - 01/09/18	04/30/18	0.00	2,605.00	0.00	0.00	0.00
615	2318100000211	10/27/17 - 11/10/17	04/30/18	0.00	4,793.00	0.00	0.00	0.00
615	2018117070814	12/02/17 - 12/05/17	05/07/18	0.00	4,793.00	0.00	0.00	0.00
615	2018122085174	03/22/18 - 04/13/18	05/07/18	0.00	5,210.00	0.00	0.00	0.00
615	2318131000449	08/16/17 - 08/19/17	05/28/18	0.00	7,398.00	0.00	0.00	0.00
615	2318135000037	04/01/18 - 04/02/18	05/28/18	0.00	2,605.00	0.00	967.69	0.00
615	2318138000136	02/03/18 - 02/04/18	06/04/18	0.00	4,793.00	0.00	0.00	0.00
615	2218150000889	04/03/18 - 04/08/18	06/04/18	0.00	2,605.00	0.00	0.00	0.00
615	2018152088817	05/24/18 - 05/25/18	06/11/18	0.00	4,793.00	0.00	0.00	0.00
615	2018173019627	06/04/18 - 06/05/18	06/25/18	0.00	4,793.00	0.00	0.00	0.00
615	2018183033790	06/20/18 - 06/21/18	07/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318228000295	03/26/18 - 04/09/18	09/10/18	0.00	4,793.00	0.00	0.00	0.00
615	2318257000275	04/21/18 - 05/10/18	10/15/18	0.00	2,605.00	0.00	0.00	0.00
615	5219024000168	12/10/17 - 02/19/18	01/28/19	0.00	4,793.00	0.00	0.00	0.00
615	5219058000054	12/31/17 - 08/03/18	03/04/19	0.00	2,188.00	0.00	0.00	0.00
615	2019218093158	05/22/18 - 05/30/18	08/12/19	0.00	4,793.00	0.00	0.00	0.00
TOTAL				0.00	159,924.00	0.00	18,042.72	0.00

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,388,619.44	ADJUSTMENTS	0.00
COVERED CHARGES	1,353,098.44	CONTRACTUAL ALLOW	580,878.78
NON-COVERD CHARGES	35,521.00	TOTAL MEDICAID LIAB	772,219.66
		LESS: COB	772,219.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	68	0	107,576.00	29,805.00
ROUTINE NURSERY	208	0	422,881.00	2,074.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	276	0	530,457.00	31,879.00
SPECIAL CARE SERVICES				
CCU	2	0	8,814.00	0.00
ICU	32	0	93,433.00	0.00
NICU	14	0	54,908.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	48	0	157,155.00	0.00
TOTAL ACCOMODATIONS	324	0	687,612.00	31,879.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,062.67	0.00	OTHER LAB	9,532.00	0.00
MED/SURG SUPPLY	10,875.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	70,185.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,532.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	532.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,268.00	0.00	MRI SERVICES	13,754.00	0.00
IV THERAPY	1,847.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,230.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,460.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89,100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,422.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,129.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,995.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,222.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,712.00	0.00	INJECTABLE DRUGS	19,206.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,576.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	298.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,991.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,626.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,215.00	3,642.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,154.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	131,712.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,853.00	0.00			

TOTAL ANCILLARY	665,486.44	3,642.00
TOTAL ACCOMODATIONS	687,612.00	31,879.00
TOTAL CHARGES	1,353,098.44	35,521.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,759,300.38	ADJUSTMENTS	1,489,315.38
COVERED CHARGES	23,628,385.31	CONTRACTUAL ALLOW	19,022,089.03
NON-COVERD CHARGES	3,130,915.07	TOTAL MEDICAID LIAB	4,606,296.28
		LESS: COB	14,187.48
		LESS: COPAYMENT	10,484.33
		REIMBURSEMENT	4,581,624.47
		ALL OTHER	3,321,039.99
		FEE SCHEDULE-LAB	211,737.09
		INJECTABLE DRUGS	1,048,847.39

TOTAL NUMBER OF CLAIMS 7,996

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,300.00	212.00	OTHER LAB	251,865.00	0.00
MED/SURG SUPPLY	79,268.00	67,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	40.00	508.00
RADIOLOGY-DIAGNOSTIC	1,129,960.00	79,407.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,142,427.00	617,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	90,141.00	6,988.17	FEE SCHEDULE LAB	2,071,618.50	119,898.00
EKG/ECG	456,932.00	1,756.00	MRI SERVICES	402,731.00	134,746.00
IV THERAPY	1,643,480.00	110,212.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,482,710.41	392,816.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,902.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88,416.00	26,863.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	485,632.00	3,282.00	AMBULANCE	0.00	0.00
GI SERVICES	95,544.50	33,853.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,266,005.00	25,303.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	351,760.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	827.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,448,182.90	267,622.23
RADIOLOGY THERAPEUTIC	0.00	6,749.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,842.00	6,864.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,634.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	190,950.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	129,726.00	18,181.00	TRAUMA RESPONSE	0.00	100,802.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,761.00	225,795.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	45,301.00
OTHER IMAGING SERVICE	1,089,255.00	122,460.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,310.00	33,992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	413,486.00	253,802.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	656,536.00	219,454.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,901.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	414,653.00	10,363.00			

TOTAL ANCILLARY	23,628,385.31	3,129,333.07
TOTAL ACCOMODATIONS	0.00	1,582.00
TOTAL CHARGES	23,628,385.31	3,130,915.07

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017270000877	08/28/17 - 08/28/17	10/02/17	0.00	2,605.00	0.00	0.00	0.00
615	2017270000877	08/28/17 - 08/28/17	10/02/17	0.00	2,188.00	0.00	0.00	0.00
241	5917340000480	08/29/17 - 08/29/17	12/11/17	0.00	397.00	0.00	0.00	0.00
241	5917349002944	09/19/17 - 09/19/17	12/18/17	0.00	397.00	0.00	0.00	0.00
615	5918037000105	09/16/17 - 09/16/17	02/12/18	0.00	2,605.00	0.00	0.00	0.00
615	5918081000157	01/31/18 - 01/31/18	03/26/18	0.00	2,605.00	0.00	0.00	0.00
615	5918081000157	01/31/18 - 01/31/18	03/26/18	0.00	2,188.00	0.00	0.00	0.00
615	2018102084798	03/09/18 - 03/09/18	04/16/18	0.00	2,605.00	0.00	0.00	0.00
615	2018102084798	03/09/18 - 03/09/18	04/16/18	0.00	2,188.00	0.00	0.00	0.00
615	5918116001229	03/08/18 - 03/08/18	04/30/18	0.00	2,605.00	0.00	0.00	0.00
615	5918116001229	03/08/18 - 03/08/18	04/30/18	0.00	2,188.00	0.00	0.00	0.00
242	2218165004531	12/12/17 - 12/12/17	06/18/18	0.00	397.00	0.00	0.00	0.00
615	5918166000111	05/08/18 - 05/08/18	06/18/18	0.00	2,605.00	0.00	0.00	0.00
615	5918166000111	05/08/18 - 05/08/18	06/18/18	0.00	2,188.00	0.00	0.00	0.00
613	5918172001415	01/04/18 - 01/04/18	06/25/18	0.00	4,679.00	0.00	0.00	0.00
615	2018197046158	03/20/18 - 03/20/18	07/23/18	0.00	2,605.00	0.00	0.00	0.00
615	2018197046158	03/20/18 - 03/20/18	07/23/18	0.00	2,188.00	0.00	0.00	0.00
615	5918213000172	04/13/18 - 04/13/18	08/06/18	0.00	2,878.00	0.00	0.00	0.00
615	2218235006963	06/14/18 - 06/14/18	08/27/18	0.00	2,605.00	0.00	0.00	0.00
615	2218235006963	06/14/18 - 06/14/18	08/27/18	0.00	2,188.00	0.00	0.00	0.00
242	5918248000361	06/12/18 - 06/12/18	09/10/18	0.00	397.00	0.00	0.00	0.00
TOTAL				0.00	45,301.00	0.00	0.00	0.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	518,390.52	ADJUSTMENTS	0.00
COVERED CHARGES	283,278.50	CONTRACTUAL ALLOW	51,646.74
NON-COVERD CHARGES	235,112.02	TOTAL MEDICAID LIAB	231,631.76
		LESS: COB	231,494.10
		LESS: COPAYMENT	137.66
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	102

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,583.00	0.00	OTHER LAB	13,495.00	0.00
MED/SURG SUPPLY	2,486.00	23,053.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	78.00
RADIOLOGY-DIAGNOSTIC	15,612.00	11,722.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,461.00	50,425.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,606.00	762.02	FEE SCHEDULE LAB	32,646.00	1,743.00
EKG/ECG	7,463.00	439.00	MRI SERVICES	0.00	6,467.00
IV THERAPY	17,338.00	3,480.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,826.00	93,297.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,586.00	2,166.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,669.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	433.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,773.00	372.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,827.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,883.50	3,862.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,601.00	224.00	TRAUMA RESPONSE	0.00	5,355.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,226.00	3,352.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,251.00	5,182.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,014.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,721.00	22,441.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,336.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,442.00	692.00			

TOTAL ANCILLARY	283,278.50	235,112.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	283,278.50	235,112.02

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,127,227.00	ADJUSTMENTS	1,565.26
COVERED CHARGES	1,053,630.00	CONTRACTUAL ALLOW	1,021,688.26
NON-COVERD CHARGES	73,597.00	TOTAL MEDICAID LIAB	31,941.74
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	31,206.74

TOTAL NUMBER OF CLAIMS 571

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,610.00	0.00	OTHER LAB	5,145.00	0.00
MED/SURG SUPPLY	917.00	1,433.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,548.00	3,557.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	134,081.00	27,990.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	154,125.00	3,120.00
EKG/ECG	15,365.00	0.00	MRI SERVICES	19,165.00	0.00
IV THERAPY	66,178.00	2,451.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,377.00	13,912.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,029.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	522,861.00	581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,292.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,653.00	2,755.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,976.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,346.00	13,552.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,200.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,500.00	1,270.00			

TOTAL ANCILLARY	1,053,630.00	73,597.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,053,630.00	73,597.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,021.00	ADJUSTMENTS	0.00
COVERED CHARGES	54,170.00	CONTRACTUAL ALLOW	25,153.99
NON-COVERD CHARGES	13,851.00	TOTAL MEDICAID LIAB	29,016.01
		LESS: COB	29,001.01
		LESS: COPAYMENT	15.00
		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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,175.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,302.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,445.00	11,994.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,360.00	116.00
EKG/ECG	439.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,884.00	302.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,892.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,756.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,402.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,177.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,107.00	803.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	636.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,149.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	54,170.00	13,851.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	54,170.00	13,851.00

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,071,477.79	ADJUSTMENTS	387,041.12
COVERED CHARGES	4,440,513.69	CONTRACTUAL ALLOW	3,422,032.71
NON-COVERD CHARGES	630,964.10	TOTAL MEDICAID LIAB	1,018,480.98
		LESS: COB	2,450.50
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	1,015,493.48

TOTAL NUMBER OF CLAIMS 184

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,808.00	0.00	OTHER LAB	5,453.00	0.00
MED/SURG SUPPLY	16,178.00	54,689.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,078.00	16,948.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,064.00	5,204.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,304.00	9,524.00
EKG/ECG	4,829.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	178,728.00	19,944.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	229,905.00	10,105.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,505.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,493.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,235.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,663,832.69	433,393.10
RADIOLOGY THERAPEUTIC	241.00	1,191.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,301.00	36,555.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,520.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,476.00	3,316.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	114,669.00	40,095.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,854.00	0.00			

TOTAL ANCILLARY	4,440,513.69	630,964.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,440,513.69	630,964.10

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,016,220.60	ADJUSTMENTS	279,662.51
COVERED CHARGES	44,914,092.45	CONTRACTUAL ALLOW	31,107,865.50
NON-COVERD CHARGES	2,102,128.15	TOTAL MEDICAID LIAB	13,806,226.95
		LESS: COB	192,743.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,613,483.36

TOTAL NUMBER OF ADMISSIONS 1,619

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,760	0	5,005,936.19	143,056.76
ROUTINE NURSERY	1,111	0	1,801,547.28	2,234.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,871	0	6,807,483.47	145,290.76
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	966	0	2,678,140.65	0.00
NICU	28	0	91,616.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	994	0	2,769,756.65	0.00
TOTAL ACCOMODATIONS	6,865	0	9,577,240.12	145,290.76

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,547,142.00	0.00	OTHER LAB	325,620.28	0.00
MED/SURG SUPPLY	2,554,396.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,807,315.55	0.00	EDUCATION & TRAINING	44,567.11	0.00
RADIOLOGY-DIAGNOSTIC	814,556.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,695,479.28	1,350,413.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	234,138.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	406,729.04	0.00	MRI SERVICES	623,754.07	0.00
IV THERAPY	118,625.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,937,521.39	66,681.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	663,458.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,637,510.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	606,647.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	302,031.79	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,842,252.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,673.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	260,694.87	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	68,400.60	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	135,045.74	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	276,437.24	4,503.55	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63,963.03	409.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,084,156.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	352,408.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	447,320.33	33,622.44			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	618,566.20	106,367.63			
AUDIOLOGY	28,311.00	394,839.08			
CARDIOLOGY	2,260,643.91	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,141.88	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215,342.82	0.00			

TOTAL ANCILLARY	35,336,852.33	1,956,837.39
TOTAL ACCOMODATIONS	9,577,240.12	145,290.76
TOTAL CHARGES	44,914,092.45	2,102,128.15

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	280,783.68	ADJUSTMENTS	0.00
COVERED CHARGES	280,693.68	CONTRACTUAL ALLOW	234,695.18
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	45,998.50
		LESS: COB	45,998.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,411.74	90.00
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	5,411.74	90.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	5,444.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	5,444.00	0.00
TOTAL ACCOMODATIONS	7	0	10,855.74	90.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,650.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	68,966.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,908.32	0.00	EDUCATION & TRAINING	185.85	0.00
RADIOLOGY-DIAGNOSTIC	9,101.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,214.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	335.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,306.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	410.55	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,002.35	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	808.08	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,627.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,096.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	20,700.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	130,343.45	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	0.00	0.00			

TOTAL ANCILLARY	269,837.94	0.00
TOTAL ACCOMODATIONS	10,855.74	90.00
TOTAL CHARGES	280,693.68	90.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,534,319.90	ADJUSTMENTS	425,071.86
COVERED CHARGES	16,750,867.04	CONTRACTUAL ALLOW	14,538,995.96
NON-COVERD CHARGES	1,783,452.86	TOTAL MEDICAID LIAB	2,211,871.08
		LESS: COB	5,965.19
		LESS: COPAYMENT	3,300.60
		REIMBURSEMENT	2,202,605.29
		ALL OTHER	2,027,143.90
		FEE SCHEDULE-LAB	153,320.98
		INJECTABLE DRUGS	22,140.41

TOTAL NUMBER OF CLAIMS 4,324

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,659.69	24,837.94	OTHER LAB	387,527.67	8,487.53
MED/SURG SUPPLY	362,351.46	34,433.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	198.79	0.00
RADIOLOGY-DIAGNOSTIC	626,224.78	68,778.73	OTHER THERAPEUTIC SVC	0.00	5,913.08
CT SCAN	1,987,211.82	409,338.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,861.34	19,819.80	FEE SCHEDULE LAB	4,241,425.51	372,544.09
EKG/ECG	199,220.52	27,313.04	MRI SERVICES	132,961.68	14,519.40
IV THERAPY	181,778.30	38,258.93	PROFESSIONAL FEES	0.00	44.10
OPERATING ROOM	1,363,781.70	236,843.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,492.17	1,336.90	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	195,934.90	48,075.73	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	239,801.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	197,934.88	40,208.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,880,953.14	184,205.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,498.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272,030.06	41,348.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,858.13	3,824.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,555.78	969.13	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,729.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,641.10	9,162.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69,322.39	8,165.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	666,386.01	74,886.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,552.87	1,203.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,702.30	47,141.65			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	180,964.54	36,427.05			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,053.21	0.00			
ORGAN ACQUISITION	0.00	10,462.29			
TREATMENT/OBSERV. RM	60,982.31	9,174.35			

TOTAL ANCILLARY	16,750,867.04	1,783,452.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,750,867.04	1,783,452.86

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,634.09	ADJUSTMENTS	0.00
COVERED CHARGES	11,109.50	CONTRACTUAL ALLOW	7,854.84
NON-COVERD CHARGES	2,524.59	TOTAL MEDICAID LIAB	3,254.66
		LESS: COB	3,254.66
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	953.24	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	870.57	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	1,323.64	222.11
EKG/ECG	693.32	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,284.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,196.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,834.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238.04	18.14
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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,109.50	2,524.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,109.50	2,524.59

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,410.38	ADJUSTMENTS	3,488.89
COVERED CHARGES	205,823.10	CONTRACTUAL ALLOW	196,850.18
NON-COVERD CHARGES	3,587.28	TOTAL MEDICAID LIAB	8,972.92
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	8,783.92
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.11	7.04	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	5,578.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,594.31	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,268.66	2,703.89
EKG/ECG	2,056.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	141,421.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	461.04	66.62
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,149.38	809.73			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	205,823.10	3,587.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,823.10	3,587.28

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,709.87	ADJUSTMENTS	0.00
COVERED CHARGES	5,594.96	CONTRACTUAL ALLOW	4,539.02
NON-COVERD CHARGES	8,114.91	TOTAL MEDICAID LIAB	1,055.94
		LESS: COB	1,052.94
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	308.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	142.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	467.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,033.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,345.09	81.84
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	853.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,477.78	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,594.96	8,114.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,594.96	8,114.91

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,967,593.78	ADJUSTMENTS	72,048.99
COVERED CHARGES	1,607,936.44	CONTRACTUAL ALLOW	1,428,784.55
NON-COVERD CHARGES	359,657.34	TOTAL MEDICAID LIAB	179,151.89
		LESS: COB	5,752.00
		LESS: COPAYMENT	95.60
		REIMBURSEMENT	173,304.29

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,845.62	1,881.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	254,776.60	36,083.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,794.60	15,798.26	OTHER THERAPEUTIC SVC	0.00	447.74
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,360.51	4,963.06
EKG/ECG	1,409.96	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,247.24	7,391.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	916,090.18	153,374.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,562.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,935.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,529.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,655.07	7,887.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	135,089.68	50,863.33
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,863.75	2,403.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,012.85	417.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,888.81	78,145.89			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,785.80	0.00			

TOTAL ANCILLARY	1,607,936.44	359,657.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,607,936.44	359,657.34

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,940.97	ADJUSTMENTS	0.00
COVERED CHARGES	162,005.97	CONTRACTUAL ALLOW	43,837.91
NON-COVERD CHARGES	1,935.00	TOTAL MEDICAID LIAB	118,168.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	118,168.06

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	20,000.00	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	50	0	20,000.00	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	50	0	20,000.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,332.91	0.00	OTHER LAB	327.00	0.00
MED/SURG SUPPLY	16,035.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,332.39	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,317.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,635.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,378.00	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	4,800.00	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	3,240.00	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	123.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	513.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,576.00	1,935.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,166.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	230.00	0.00			

TOTAL ANCILLARY	142,005.97	1,935.00
TOTAL ACCOMODATIONS	20,000.00	0.00
TOTAL CHARGES	162,005.97	1,935.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	513,525.17	ADJUSTMENTS	12,907.09
COVERED CHARGES	479,381.33	CONTRACTUAL ALLOW	182,629.70
NON-COVERD CHARGES	34,143.84	TOTAL MEDICAID LIAB	296,751.63
		LESS: COB	0.00
		LESS: COPAYMENT	582.00
		REIMBURSEMENT	296,169.63
		ALL OTHER	274,233.73
		FEE SCHEDULE-LAB	21,935.90
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 652

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,618.18	227.60	OTHER LAB	2,386.00	214.00
MED/SURG SUPPLY	23,721.12	519.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,127.00	4,223.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,529.50	5,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,526.00	360.00	FEE SCHEDULE LAB	170,542.53	9,066.00
EKG/ECG	14,811.00	2,945.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	38.00
OPERATING ROOM	5,481.00	1,006.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,137.00	364.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,741.00	6,055.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	896.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,137.00	570.00			
BLOOD	0.00	0.00			
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	1,083.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,240.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,405.00	1,521.00			

TOTAL ANCILLARY	479,381.33	34,143.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	479,381.33	34,143.84

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	621.66	ADJUSTMENTS	0.00
COVERED CHARGES	529.57	CONTRACTUAL ALLOW	28.28
NON-COVERD CHARGES	92.09	TOTAL MEDICAID LIAB	501.29
		LESS: COB	501.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.67	92.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	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	200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	529.57	92.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	529.57	92.09

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,734.45	ADJUSTMENTS	141.00
COVERED CHARGES	32,880.31	CONTRACTUAL ALLOW	29,430.31
NON-COVERD CHARGES	854.14	TOTAL MEDICAID LIAB	3,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	3,336.00
		TOTAL NUMBER OF CLAIMS	69

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,595.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	760.89	51.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,849.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,765.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,058.40	758.00
EKG/ECG	486.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,366.00	45.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,880.31	854.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,880.31	854.14

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,791.52	ADJUSTMENTS	5,785.12
COVERED CHARGES	22,698.52	CONTRACTUAL ALLOW	5,343.16
NON-COVERD CHARGES	1,093.00	TOTAL MEDICAID LIAB	17,355.36
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,355.36
		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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,087.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,617.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,866.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,274.00	90.00
EKG/ECG	751.00	530.00	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	64.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,294.00	293.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,511.00	180.00			

TOTAL ANCILLARY	22,698.52	1,093.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,698.52	1,093.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,027,681.07	ADJUSTMENTS	3,136,531.05
COVERED CHARGES	86,873,670.82	CONTRACTUAL ALLOW	69,579,473.65
NON-COVERD CHARGES	6,154,010.25	TOTAL MEDICAID LIAB	17,294,197.17
		LESS: COB	172,414.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,121,782.93

TOTAL NUMBER OF ADMISSIONS 2,124

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,053	0	7,726,772.00	2,017,190.00
ROUTINE NURSERY	1,463	0	2,035,411.00	30,002.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,516	0	9,762,183.00	2,047,192.00
SPECIAL CARE SERVICES				
CCU	2,344	0	5,736,636.00	170,309.00
ICU	958	0	3,498,398.00	241,248.00
NICU	526	0	1,801,682.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	228	0	468,582.00	759,426.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,056	0	11,505,298.00	1,170,983.00
TOTAL ACCOMODATIONS	11,572	0	21,267,481.00	3,218,175.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,658,531.30	519,349.15	OTHER LAB	672,856.99	61,590.50
MED/SURG SUPPLY	2,386,819.29	135,728.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,769,333.29	355,334.00	EDUCATION & TRAINING	55,086.00	0.00
RADIOLOGY-DIAGNOSTIC	1,548,652.00	101,109.00	OTHER THERAPEUTIC SVC	0.00	49,118.00
CT SCAN	4,507,165.37	95,678.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	463,378.78	50,002.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	663,573.00	12,725.50	MRI SERVICES	1,020,666.00	32,651.00
IV THERAPY	1,048,469.00	18,631.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,864,387.26	209,116.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,148,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,430,268.71	667,133.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,488,534.55	70,125.00	AMBULANCE	0.00	0.00
GI SERVICES	71,475.00	5,080.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,884,622.00	7,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,053,346.00	10,158.43	DRUG-SPECIFIC/HOME IV	0.00	17,242.00
LABORATORY PATHOLOGIC	414,787.21	11,149.00	INJECTABLE DRUGS	18,686.29	0.00
RADIOLOGY THERAPEUTIC	77,973.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	313,105.79	25,122.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	196,039.89	33,399.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,030,612.00	102,084.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51,075.00	8,645.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	280,483.00	0.00	IMPL DEV CHARGE PATIENTS	1,455,208.55	134,636.36
LITHOTRIPSY	39,464.00	0.00	NO CC/INVALID REV CODE	0.00	157.00
OTHER IMAGING SERVICE	654,797.42	2,570.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,116,718.00	172,783.07			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	504,059.23	6,152.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,920,517.81	9,637.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	181,955.00	3,444.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	614,823.09	8,158.23			

TOTAL ANCILLARY	65,606,189.82	2,935,835.25
TOTAL ACCOMODATIONS	21,267,481.00	3,218,175.00
TOTAL CHARGES	86,873,670.82	6,154,010.25

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 07/01/17 THROUGH 06/30/18
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	2018114061288	02/24/18 - 03/09/18	04/30/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	157.00	0.00	0.00	0.00

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

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

PROVIDER NUMBER 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,109,604.95	ADJUSTMENTS	0.00
COVERED CHARGES	1,103,052.95	CONTRACTUAL ALLOW	575,068.52
NON-COVERD CHARGES	6,552.00	TOTAL MEDICAID LIAB	527,984.43
		LESS: COB	527,984.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	117	0	151,164.00	6,552.00
ROUTINE NURSERY	30	0	18,564.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	147	0	169,728.00	6,552.00
SPECIAL CARE SERVICES				
CCU	13	0	32,682.00	0.00
ICU	1	0	3,591.00	0.00
NICU	2	0	6,844.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	43,117.00	0.00
TOTAL ACCOMODATIONS	163	0	212,845.00	6,552.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,759.50	0.00	OTHER LAB	8,485.00	0.00
MED/SURG SUPPLY	37,378.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	96,957.00	0.00	EDUCATION & TRAINING	5,527.00	0.00
RADIOLOGY-DIAGNOSTIC	5,514.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,516.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	872.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,072.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,208.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	109,898.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	360,190.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,767.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,384.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,085.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,206.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	382.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,938.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	999.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,711.59	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,023.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,551.10	0.00			

TOTAL ANCILLARY	890,207.95	0.00
TOTAL ACCOMODATIONS	212,845.00	6,552.00
TOTAL CHARGES	1,103,052.95	6,552.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,312,948.69	ADJUSTMENTS	723,131.79
COVERED CHARGES	28,636,864.27	CONTRACTUAL ALLOW	24,715,649.35
NON-COVERD CHARGES	3,676,084.42	TOTAL MEDICAID LIAB	3,921,214.92
		LESS: COB	47,935.17
		LESS: COPAYMENT	6,838.24
		REIMBURSEMENT	3,866,441.51
		ALL OTHER	3,274,100.64
		FEE SCHEDULE-LAB	353,505.06
		INJECTABLE DRUGS	238,835.81

TOTAL NUMBER OF CLAIMS 8,475

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	905,743.79	919.00	OTHER LAB	660,189.00	5,013.00
MED/SURG SUPPLY	585,671.00	30,609.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	423.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,371,724.00	20,687.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,778,312.00	663,992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,708.00	28,851.00	FEE SCHEDULE LAB	4,507,771.93	264,709.12
EKG/ECG	539,136.00	3,584.00	MRI SERVICES	618,737.00	77,040.00
IV THERAPY	1,865,630.00	91,070.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,588,576.50	431,369.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	102,771.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	116,012.00	120,449.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	750,459.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,250.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,195,904.00	16,792.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	593,319.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,362.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,403,782.99	753,994.00
RADIOLOGY THERAPEUTIC	15,544.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,246.00	9,186.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,624.00	2,269.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	425,148.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69,457.00	21,205.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	179,547.00	108,777.00	IMPL DEV CHARGE PATIENTS	255,737.06	30,324.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	814,161.00	291,437.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	417,399.00	58,284.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	485,157.00	145,712.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	616,827.00	68,878.00			

TOTAL ANCILLARY	28,636,864.27	3,676,084.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,636,864.27	3,676,084.42

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	531,906.34	ADJUSTMENTS	0.00
COVERED CHARGES	420,851.86	CONTRACTUAL ALLOW	234,572.94
NON-COVERD CHARGES	111,054.48	TOTAL MEDICAID LIAB	186,278.92
		LESS: COB	186,248.92
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 118

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,198.00	510.00	OTHER LAB	19,295.00	0.00
MED/SURG SUPPLY	7,923.41	942.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,132.00	545.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,154.00	34,174.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	71,063.98	5,475.54
EKG/ECG	6,144.00	0.00	MRI SERVICES	0.00	9,467.00
IV THERAPY	32,643.00	3,872.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,686.00	32,829.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,048.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,130.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,865.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124.00	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	111.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	556.00	IMPL DEV CHARGE PATIENTS	7,996.97	331.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,574.00	17,222.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,465.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,700.00	282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,078.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,054.50	4,848.00			

TOTAL ANCILLARY	420,851.86	111,054.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	420,851.86	111,054.48

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	884,483.12	ADJUSTMENTS	929.98
COVERED CHARGES	838,408.12	CONTRACTUAL ALLOW	815,790.74
NON-COVERD CHARGES	46,075.00	TOTAL MEDICAID LIAB	22,617.38
		LESS: COB	856.72
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	21,256.66
		TOTAL NUMBER OF CLAIMS	389

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,549.50	0.00	OTHER LAB	20,970.00	0.00
MED/SURG SUPPLY	1,953.62	186.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	189.00
RADIOLOGY-DIAGNOSTIC	52,955.00	3,777.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,247.00	7,654.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	165,747.00	7,521.00
EKG/ECG	11,776.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,282.00	666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,848.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	442,139.00	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	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	5,229.00	7,722.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,176.00	16,129.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	838,408.12	46,075.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	838,408.12	46,075.00

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,719.75	ADJUSTMENTS	0.00
COVERED CHARGES	19,719.75	CONTRACTUAL ALLOW	14,349.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,370.07
		LESS: COB	5,361.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245.75	0.00	OTHER LAB	1,990.00	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	1,338.00	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	4,084.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	8,857.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,066.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,719.75	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,719.75	0.00

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,681,270.20	ADJUSTMENTS	253,792.07
COVERED CHARGES	5,474,210.28	CONTRACTUAL ALLOW	4,839,485.47
NON-COVERD CHARGES	207,059.92	TOTAL MEDICAID LIAB	634,724.81
		LESS: COB	0.00
		LESS: COPAYMENT	674.05
		REIMBURSEMENT	634,050.76

TOTAL NUMBER OF CLAIMS 117

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,391.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100,354.31	247.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,466.00	545.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,275.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,480.00	38.00
EKG/ECG	1,024.00	512.00	MRI SERVICES	0.00	0.00
IV THERAPY	282,480.00	4,854.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	274,722.50	63,219.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,922.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,848,902.50	78,915.50
RADIOLOGY THERAPEUTIC	9,976.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,281.00	4,844.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	454,900.53	0.00
LITHOTRIPSY	108,773.00	36,857.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,842.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,046.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,671.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,753.19	4,463.00			

TOTAL ANCILLARY	5,474,210.28	207,059.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,474,210.28	207,059.92

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

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,802,418.87	ADJUSTMENTS	44,401.85
COVERED CHARGES	1,653,379.76	CONTRACTUAL ALLOW	821,604.18
NON-COVERD CHARGES	149,039.11	TOTAL MEDICAID LIAB	831,775.58
		LESS: COB	16,364.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	815,411.09

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	330	0	144,870.00	220.00
ROUTINE NURSERY	73	0	18,537.00	39.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	403	0	163,407.00	259.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	113	0	119,677.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	113	0	119,677.00	0.00
TOTAL ACCOMODATIONS	516	0	283,084.00	259.00

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PROVIDER NUMBER
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SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,504.09	0.00	OTHER LAB	4,371.00	0.00
MED/SURG SUPPLY	29,623.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	298,109.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,637.00	0.00	OTHER THERAPEUTIC SVC	0.00	182.00
CT SCAN	0.00	141,471.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,931.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,493.00	0.00	MRI SERVICES	6,847.00	0.00
IV THERAPY	59,130.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,689.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	80,247.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,072.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,232.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,243.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,359.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,991.00	0.00	INJECTABLE DRUGS	296,386.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,944.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.11
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	146.00	1,136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	89,016.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,565.00
OTHER IMAGING SERVICE	5,880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,765.00	811.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,972.00	1,614.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,214.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,942.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,550.00	0.00			

TOTAL ANCILLARY	1,370,295.76	148,780.11
TOTAL ACCOMODATIONS	283,084.00	259.00
TOTAL CHARGES	1,653,379.76	149,039.11

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2217296004672	09/24/17 - 09/29/17	10/30/17	0.00	2,000.00	0.00	0.00	0.00
614	2018166001059	05/26/18 - 06/04/18	06/18/18	0.00	1,565.00	0.00	0.00	0.00
TOTAL				0.00	3,565.00	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 MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,713,204.82	ADJUSTMENTS	91,661.80
COVERED CHARGES	3,363,349.23	CONTRACTUAL ALLOW	2,500,652.80
NON-COVERD CHARGES	349,855.59	TOTAL MEDICAID LIAB	862,696.43
		LESS: COB	934.35
		LESS: COPAYMENT	1,551.00
		REIMBURSEMENT	860,211.08
		ALL OTHER	764,250.90
		FEE SCHEDULE-LAB	81,326.31
		INJECTABLE DRUGS	14,633.87

TOTAL NUMBER OF CLAIMS 2,237

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,429.58	11,592.17	OTHER LAB	21,055.00	534.00
MED/SURG SUPPLY	14,188.00	359.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	178,736.00	3,566.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	612,510.00	87,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,573.00	11,553.00	FEE SCHEDULE LAB	622,141.00	28,763.00
EKG/ECG	58,338.00	3,281.00	MRI SERVICES	107,392.00	7,281.00
IV THERAPY	238,604.00	33,532.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,047.50	14,207.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	596.00	148.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,338.00	5,572.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	218.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,355.00	13,945.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	813,930.00	17,957.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,214.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	219.00	INJECTABLE DRUGS	152,681.15	32,254.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,440.00	921.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,136.00	3,650.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,183.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,753.00
OTHER IMAGING SERVICE	66,838.00	1,707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,936.00	4,866.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,060.00	44,151.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,618.00	17,765.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,343.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,449.00	193.00			

TOTAL ANCILLARY	3,363,349.23	349,855.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,363,349.23	349,855.59

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017229001644	08/04/17 - 08/04/17	08/21/17	0.00	2,838.00	0.00	0.00	0.00
614	2017333079459	11/10/17 - 11/10/17	12/04/17	0.00	1,915.00	0.00	0.00	0.00
TOTAL				0.00	4,753.00	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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,850.80	ADJUSTMENTS	0.00
COVERED CHARGES	49,100.40	CONTRACTUAL ALLOW	15,033.83
NON-COVERD CHARGES	14,750.40	TOTAL MEDICAID LIAB	34,066.57
		LESS: COB	34,045.44
		LESS: COPAYMENT	21.13
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

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

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

PROVIDER NUMBER
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SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	606.30	165.00	OTHER LAB	891.00	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	631.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,098.00	8,552.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,743.00	1,794.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,731.00	0.00
IV THERAPY	2,726.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,260.00	3,274.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	128.00	64.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,285.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	333.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,584.10	175.40
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	142.00	146.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,650.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142.00	0.00			

TOTAL ANCILLARY	49,100.40	14,750.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,100.40	14,750.40

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	205,811.90	ADJUSTMENTS	52.94
COVERED CHARGES	195,994.85	CONTRACTUAL ALLOW	185,198.43
NON-COVERD CHARGES	9,817.05	TOTAL MEDICAID LIAB	10,796.42
		LESS: COB	0.00
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	10,466.42
		TOTAL NUMBER OF CLAIMS	193

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 PARKWAY
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254.85	188.05	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	11,097.00	567.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,373.00	3,936.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,653.00	1,422.00
EKG/ECG	3,281.00	193.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,067.00	879.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,278.00	126.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,068.00	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	6,525.00	1,035.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,398.00	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	1,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	195,994.85	9,817.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	195,994.85	9,817.05

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	701.00	ADJUSTMENTS	0.00
COVERED CHARGES	701.00	CONTRACTUAL ALLOW	224.32
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	476.68
		LESS: COB	476.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	408.00	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	293.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	701.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	701.00	0.00

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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,143,099.04	ADJUSTMENTS	397,480.14
COVERED CHARGES	11,841,511.04	CONTRACTUAL ALLOW	8,332,690.33
NON-COVERD CHARGES	301,588.00	TOTAL MEDICAID LIAB	3,508,820.71
		LESS: COB	79,554.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,429,266.15

TOTAL NUMBER OF ADMISSIONS 406

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,283	0	971,374.00	3,969.00
ROUTINE NURSERY	45	0	32,880.00	28.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,328	0	1,004,254.00	3,997.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	313	0	430,484.00	0.00
NICU	1	0	810.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	314	0	431,294.00	0.00
TOTAL ACCOMODATIONS	1,642	0	1,435,548.00	3,997.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,271,029.53	179.00	OTHER LAB	74,253.00	0.00
MED/SURG SUPPLY	510,976.00	603.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,238,009.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	285,006.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	630,992.00	3,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	105,732.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	301,703.00	0.00	MRI SERVICES	70,017.00	0.00
IV THERAPY	166,025.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,309,732.00	48,718.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,091.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	730,823.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,184.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,661.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	305,412.00	0.00	SPECIAL SERVICES	0.00	258.00
RECOVERY ROOM	47,428.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	122,813.00
LABORATORY PATHOLOGIC	23,187.00	0.00	INJECTABLE DRUGS	159,549.37	0.00
RADIOLOGY THERAPEUTIC	210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,091.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,180.39	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	100,962.00	14,220.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	630.00	1,464.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	839,880.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,504.00
OTHER IMAGING SERVICE	31,493.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,796.00	92,106.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	163,668.00	4,771.00			
AUDIOLOGY	6,344.00	0.00			
CARDIOLOGY	544,669.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,512.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189,716.96	0.00			

TOTAL ANCILLARY	10,405,963.04	297,591.00
TOTAL ACCOMODATIONS	1,435,548.00	3,997.00
TOTAL CHARGES	11,841,511.04	301,588.00

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 01/01/18 THROUGH 12/31/18
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	2018060076270	02/23/18 - 02/24/18	03/05/18	0.00	5,707.00	0.00	0.00	0.00
615	9718285957002	01/10/18 - 02/08/18	10/15/18	0.00	2,797.00	0.00	0.00	0.00
TOTAL				0.00	8,504.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,912.04	ADJUSTMENTS	0.00
COVERED CHARGES	150,643.04	CONTRACTUAL ALLOW	98,682.16
NON-COVERD CHARGES	1,269.00	TOTAL MEDICAID LIAB	51,960.88
		LESS: COB	51,960.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	22	0	16,720.00	198.00
ROUTINE NURSERY	5	0	3,650.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27	0	20,370.00	198.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	4,940.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,940.00	0.00
TOTAL ACCOMODATIONS	31	0	25,310.00	198.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,852.00	0.00	OTHER LAB	810.00	0.00
MED/SURG SUPPLY	10,101.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,188.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,943.00	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	1,877.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	338.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,288.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,808.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,066.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	668.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	273.00	0.00	INJECTABLE DRUGS	2,319.00	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	729.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	862.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	442.00	1,071.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	488.00	0.00			
CARDIOLOGY	39,430.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,893.04	0.00			

TOTAL ANCILLARY	125,333.04	1,071.00
TOTAL ACCOMODATIONS	25,310.00	198.00
TOTAL CHARGES	150,643.04	1,269.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,597,813.96	ADJUSTMENTS	540,672.80
COVERED CHARGES	11,838,050.30	CONTRACTUAL ALLOW	9,909,162.66
NON-COVERD CHARGES	759,763.66	TOTAL MEDICAID LIAB	1,928,887.64
		LESS: COB	31,679.42
		LESS: COPAYMENT	5,508.27
		REIMBURSEMENT	1,891,699.95
		ALL OTHER	1,637,232.41
		FEE SCHEDULE-LAB	158,955.86
		INJECTABLE DRUGS	95,511.68

TOTAL NUMBER OF CLAIMS 4,410

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391,665.00	396.00	OTHER LAB	99,595.00	0.00
MED/SURG SUPPLY	342,836.99	3,530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504,785.98	47,361.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,453,481.00	76,666.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,641.00	3,311.05	FEE SCHEDULE LAB	2,112,660.96	105,063.00
EKG/ECG	218,940.00	200.00	MRI SERVICES	308,678.00	25,419.00
IV THERAPY	525,898.00	154,527.00	PROFESSIONAL FEES	0.00	707.00
OPERATING ROOM	1,266,321.64	39,674.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,152.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	239,398.00	9,286.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	275,881.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	163,929.00	300.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,198,997.09	2,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	16,875.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	483,063.21	75,525.08
RADIOLOGY THERAPEUTIC	15,348.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,571.00	2,677.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,440.00	305.15	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,679.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	127,055.00	5,030.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	147,039.00	2,700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	200,465.99	11,809.02			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,491.00	7,497.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	389,411.00	2,488.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	554,504.00	90,862.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,916.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	678,765.44	65,904.00			

TOTAL ANCILLARY	11,838,050.30	759,667.66
TOTAL ACCOMODATIONS	0.00	96.00
TOTAL CHARGES	11,838,050.30	759,763.66

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	113,312.00	ADJUSTMENTS	0.00
COVERED CHARGES	97,541.97	CONTRACTUAL ALLOW	52,228.71
NON-COVERD CHARGES	15,770.03	TOTAL MEDICAID LIAB	45,313.26
		LESS: COB	45,295.26
		LESS: COPAYMENT	18.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,539.00	0.00	OTHER LAB	640.00	0.00
MED/SURG SUPPLY	5,919.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,719.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,273.00	3,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278.00	446.00	FEE SCHEDULE LAB	24,550.00	1,945.00
EKG/ECG	877.00	0.00	MRI SERVICES	2,702.00	6,920.00
IV THERAPY	6,853.00	676.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,544.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,336.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	816.00	382.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	305.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,518.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,492.97	1,700.00			

TOTAL ANCILLARY	97,541.97	15,770.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	97,541.97	15,770.03

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	400,385.11	ADJUSTMENTS	9,573.18
COVERED CHARGES	368,992.49	CONTRACTUAL ALLOW	341,225.47
NON-COVERD CHARGES	31,392.62	TOTAL MEDICAID LIAB	27,767.02
		LESS: COB	4,092.68
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	23,137.34
		TOTAL NUMBER OF CLAIMS	352

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,277.00	38.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,066.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,937.99	599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,935.00	4,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	96,212.00	4,989.00
EKG/ECG	4,276.99	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,841.00	2,028.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,767.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	152,621.02	1,051.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,606.00	15,633.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,572.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,892.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,110.00	752.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	878.49	1,834.62			

TOTAL ANCILLARY	368,992.49	31,392.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	368,992.49	31,392.62

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,414.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,993.01	CONTRACTUAL ALLOW	7,264.42
NON-COVERD CHARGES	420.99	TOTAL MEDICAID LIAB	3,728.59
		LESS: COB	3,713.54
		LESS: COPAYMENT	15.05
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	266.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	987.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,828.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,206.98	26.99
EKG/ECG	599.98	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	384.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	427.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,091.05	384.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	138.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,993.01	420.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,993.01	420.99

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,139,997.80	ADJUSTMENTS	193,636.68
COVERED CHARGES	1,930,765.78	CONTRACTUAL ALLOW	1,636,030.48
NON-COVERD CHARGES	209,232.02	TOTAL MEDICAID LIAB	294,735.30
		LESS: COB	56,607.77
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	237,956.53

TOTAL NUMBER OF CLAIMS 44

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,941.00	0.00	OTHER LAB	5,245.00	0.00
MED/SURG SUPPLY	118,919.00	65.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,797.00	38,852.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,380.00	1,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,774.00	FEE SCHEDULE LAB	32,750.00	1,472.00
EKG/ECG	4,400.00	400.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,959.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	517,796.00	4,661.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,042.00	1,220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,899.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,635.00	288.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	226,525.03	53,357.02
RADIOLOGY THERAPEUTIC	8,753.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	414,421.00	7,500.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,780.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,721.00	87,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	434,352.75	10,654.00			

TOTAL ANCILLARY	1,930,765.78	209,232.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,930,765.78	209,232.02

GEORGIA DEPARTMENT OF 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,621.01	ADJUSTMENTS	0.00
COVERED CHARGES	72,793.01	CONTRACTUAL ALLOW	-1,560.08
NON-COVERD CHARGES	47,828.00	TOTAL MEDICAID LIAB	74,353.09
		LESS: COB	74,347.09
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	159.00	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	666.00	27.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	730.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,105.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	37,456.01	47,801.00
RADIOLOGY THERAPEUTIC	1,434.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	16,177.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	72,793.01	47,828.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,793.01	47,828.00

** 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 CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,010,470.65	ADJUSTMENTS	2,119,816.78
COVERED CHARGES	69,078,211.88	CONTRACTUAL ALLOW	56,742,832.74
NON-COVERD CHARGES	5,932,258.77	TOTAL MEDICAID LIAB	12,335,379.14
		LESS: COB	72,464.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,262,914.18

TOTAL NUMBER OF ADMISSIONS 1,142

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,419	0	6,745,951.00	4,973,873.00
ROUTINE NURSERY	198	0	592,816.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,617	0	7,338,767.00	4,973,873.00
SPECIAL CARE SERVICES				
CCU	86	0	357,716.00	0.00
ICU	692	0	2,843,546.00	0.00
NICU	116	0	533,568.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	19	0	79,741.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	29	0	359,166.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	942	0	4,173,737.00	0.00
TOTAL ACCOMODATIONS	7,559	0	11,512,504.00	4,973,873.00

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,405,267.72	18,967.63	OTHER LAB	424,874.31	0.00
MED/SURG SUPPLY	2,352,194.50	15,425.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,287,367.73	5,661.27	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,160,801.24	0.00	OTHER THERAPEUTIC SVC	0.00	1,100.50
CT SCAN	3,430,044.17	669,702.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,040,939.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	425,101.75	0.00	MRI SERVICES	1,168,304.25	0.00
IV THERAPY	14,871.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,311,059.34	7,343.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	233,021.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,853,166.02	8,244.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,065,376.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	200,014.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,531,914.22	1,414.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	636,802.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	69,314.00
LABORATORY PATHOLOGIC	143,593.07	0.00	INJECTABLE DRUGS	10,270,669.83	13,456.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	851,533.89	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	239,241.88	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	341,414.57	1,317.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,531.25	69.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	728,327.50	0.00
LITHOTRIPSY	9,200.25	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	527,489.19	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	435,447.03	128,282.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	160,172.00	13,996.25			
AUDIOLOGY	243.50	0.00			
CARDIOLOGY	3,223,659.29	4,090.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,716.69	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,346.50	0.00			

TOTAL ANCILLARY	57,565,707.88	958,385.77
TOTAL ACCOMODATIONS	11,512,504.00	4,973,873.00
TOTAL CHARGES	69,078,211.88	5,932,258.77

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017258066736	08/15/17 - 08/25/17	09/25/17	0.00	0.00	0.00	0.00	0.00
24	2017268029495	09/08/17 - 09/16/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017269069474	09/08/17 - 09/19/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017271078580	09/12/17 - 09/23/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017277080950	09/07/17 - 09/15/17	10/09/17	0.00	0.00	0.00	0.00	0.00
24	2017285076354	09/15/17 - 09/25/17	10/16/17	0.00	0.00	0.00	0.00	0.00
24	2017293079026	10/05/17 - 10/13/17	10/30/17	0.00	0.00	0.00	0.00	0.00
24	2017326092398	10/27/17 - 11/07/17	11/27/17	0.00	0.00	0.00	0.00	0.00
24	2018025003817	01/05/18 - 01/17/18	01/29/18	0.00	0.00	0.00	0.00	0.00
24	5218032001225	08/15/17 - 08/25/17	03/12/18	0.00	0.00	0.00	0.00	0.00
24	2018036034901	01/12/18 - 01/28/18	02/12/18	0.00	0.00	0.00	0.00	0.00
24	2018058048446	01/27/18 - 02/09/18	03/05/18	0.00	0.00	0.00	0.00	0.00
24	2018127032176	04/10/18 - 04/18/18	05/14/18	0.00	0.00	0.00	0.00	0.00
24	2019052099189	06/22/18 - 06/27/18	02/25/19	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 CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,667.50	ADJUSTMENTS	0.00
COVERED CHARGES	96,071.50	CONTRACTUAL ALLOW	47,692.25
NON-COVERD CHARGES	596.00	TOTAL MEDICAID LIAB	48,379.25
		LESS: COB	48,379.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	9,414.00	596.00
ROUTINE NURSERY	3	0	6,146.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	15,560.00	596.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	4	0	19,368.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	19,368.00	0.00
TOTAL ACCOMODATIONS	16	0	34,928.00	596.00

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,819.50	0.00	OTHER LAB	707.00	0.00
MED/SURG SUPPLY	2,345.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,528.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,560.00	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	8,517.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,856.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,363.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,422.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,850.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,965.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,643.25	0.00	INJECTABLE DRUGS	9,816.75	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	134.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,613.75	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			

TOTAL ANCILLARY	61,143.50	0.00
TOTAL ACCOMODATIONS	34,928.00	596.00
TOTAL CHARGES	96,071.50	596.00

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,933,060.13	ADJUSTMENTS	52,399.68
COVERED CHARGES	15,086,190.00	CONTRACTUAL ALLOW	13,836,082.35
NON-COVERD CHARGES	2,846,870.13	TOTAL MEDICAID LIAB	1,250,107.65
		LESS: COB	1,561.53
		LESS: COPAYMENT	1,527.74
		REIMBURSEMENT	1,247,018.38
		ALL OTHER	1,107,990.32
		FEE SCHEDULE-LAB	132,035.52
		INJECTABLE DRUGS	6,992.54

TOTAL NUMBER OF CLAIMS 3,724

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,227.05	167,058.95	OTHER LAB	187,418.25	0.00
MED/SURG SUPPLY	411,389.75	739.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,270,571.75	177,155.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,820,145.00	699,790.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,874.50	FEE SCHEDULE LAB	3,085,804.00	233,122.00
EKG/ECG	341,722.50	465.75	MRI SERVICES	123,760.00	26,891.00
IV THERAPY	302,221.75	9,143.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	988,307.84	413,242.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,530.75	4,294.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,283.00	5,257.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	387,797.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	215,395.62	35,563.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,495,159.12	19,129.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	259,652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	10,360.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	155,250.89	214,110.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,925.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,520.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	34,242.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,429.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	9,652.50	IMPL DEV CHARGE PATIENTS	68,900.00	10,500.00
LITHOTRIPSY	18,400.50	0.00	NO CC/INVALID REV CODE	0.00	359.00
OTHER IMAGING SERVICE	339,708.25	193,001.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,753.75	9,419.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	41,266.25	30,116.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	197,073.50	517,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,967.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139,483.48	11,637.00			

TOTAL ANCILLARY	15,086,190.00	2,846,870.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,086,190.00	2,846,870.13

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
905	2017261027673	07/26/17 - 07/26/17	09/25/17	0.00	359.00	0.00	0.00	0.00
TOTAL				0.00	359.00	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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	267,617.76	ADJUSTMENTS	0.00
COVERED CHARGES	210,339.75	CONTRACTUAL ALLOW	150,102.12
NON-COVERD CHARGES	57,278.01	TOTAL MEDICAID LIAB	60,237.63
		LESS: COB	60,213.63
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,418.25	2,857.75	OTHER LAB	3,973.25	0.00
MED/SURG SUPPLY	3,188.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,990.25	884.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,112.75	13,709.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,862.00	7,701.25
EKG/ECG	3,726.00	465.75	MRI SERVICES	0.00	6,722.75
IV THERAPY	4,213.00	798.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,164.25	2,736.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	962.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	879.75	2,858.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,272.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,511.00	6,501.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,154.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,818.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,557.50	4,241.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,466.50	7,801.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,069.50	0.00			

TOTAL ANCILLARY	210,339.75	57,278.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	210,339.75	57,278.01

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,392,124.45	ADJUSTMENTS	108.88
COVERED CHARGES	1,194,786.93	CONTRACTUAL ALLOW	1,165,750.07
NON-COVERD CHARGES	197,337.52	TOTAL MEDICAID LIAB	29,036.86
		LESS: COB	0.00
		LESS: COPAYMENT	1,059.00
		REIMBURSEMENT	27,977.86
		TOTAL NUMBER OF CLAIMS	520

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,940.65	10,766.68	OTHER LAB	5,080.00	0.00
MED/SURG SUPPLY	919.75	61.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,397.00	9,196.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,142.50	130,100.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	305,054.75	16,342.75
EKG/ECG	21,545.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,315.50	849.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	343.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,271.25	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	536,679.25	1,171.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,092.03	15,749.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	281.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,007.25	12,818.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,111.00	0.00			

TOTAL ANCILLARY	1,194,786.93	197,337.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,194,786.93	197,337.52

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,456.75	ADJUSTMENTS	0.00
COVERED CHARGES	17,656.75	CONTRACTUAL ALLOW	10,359.07
NON-COVERD CHARGES	3,800.00	TOTAL MEDICAID LIAB	7,297.68
		LESS: COB	7,282.68
		LESS: COPAYMENT	15.00
		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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	3,294.00	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	5,188.00	3,543.00
EKG/ECG	465.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,634.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.00	257.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,656.75	3,800.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,656.75	3,800.00

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,423,019.96	ADJUSTMENTS	0.00
COVERED CHARGES	2,280,072.58	CONTRACTUAL ALLOW	2,171,260.58
NON-COVERD CHARGES	142,947.38	TOTAL MEDICAID LIAB	108,812.00
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	108,734.00
		TOTAL NUMBER OF CLAIMS	20

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,627.75	6,014.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	144,085.50	981.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,076.25	4,965.25	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	17,858.75	0.00
EKG/ECG	4,088.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,979.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,266,564.25	81,262.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,278.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,540.50	25.00	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	16,157.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	111,169.58	33,100.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	517,183.00	1,144.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,463.75	15,454.50			
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	0.00	0.00			

TOTAL ANCILLARY	2,280,072.58	142,947.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,280,072.58	142,947.38

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,980,955.01	ADJUSTMENTS	132,190.94
COVERED CHARGES	23,804,686.99	CONTRACTUAL ALLOW	17,839,320.70
NON-COVERD CHARGES	1,176,268.02	TOTAL MEDICAID LIAB	5,965,366.29
		LESS: COB	37,397.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,927,969.04

TOTAL NUMBER OF ADMISSIONS 562

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,837	0	1,500,763.00	701,603.00
ROUTINE NURSERY	435	0	615,007.00	255,857.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,272	0	2,115,770.00	957,460.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	501	0	1,354,437.00	0.00
NICU	10	0	39,880.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	511	0	1,394,317.00	0.00
TOTAL ACCOMODATIONS	2,783	0	3,510,087.00	957,460.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,191,946.27	33,419.40	OTHER LAB	255,091.00	0.00
MED/SURG SUPPLY	562,628.72	470.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,476,743.00	47,168.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420,934.00	441.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,752,397.00	13,359.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	206,642.34	17,767.56	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	231,246.00	2,658.00	MRI SERVICES	300,750.00	0.00
IV THERAPY	614.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,938,815.00	17,813.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	355,171.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,199,241.00	21,726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,909.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,596.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,501,065.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	442,634.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	114,625.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	5,874.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	79,881.62	12,246.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,927.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	205,598.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,299.00	10,006.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,288,750.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	202,369.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	153,350.00	16,720.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,215.00	25,014.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	547,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,778.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	213,946.75	0.00			

TOTAL ANCILLARY	20,294,599.99	218,808.02
TOTAL ACCOMODATIONS	3,510,087.00	957,460.00
TOTAL CHARGES	23,804,686.99	1,176,268.02

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	258,034.37	ADJUSTMENTS	0.00
COVERED CHARGES	232,123.37	CONTRACTUAL ALLOW	135,022.46
NON-COVERD CHARGES	25,911.00	TOTAL MEDICAID LIAB	97,100.91
		LESS: COB	97,100.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	16	0	13,904.00	8,832.00
ROUTINE NURSERY	22	0	36,046.00	16,322.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	38	0	49,950.00	25,154.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	7,701.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	7,701.00	0.00
TOTAL ACCOMODATIONS	41	0	57,651.00	25,154.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,292.73	0.00	OTHER LAB	6,805.00	0.00
MED/SURG SUPPLY	2,363.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,036.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,914.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,909.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	886.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,578.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,470.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,208.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,510.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,903.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,410.00	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	442.00	757.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,454.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,471.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,742.60	0.00			

TOTAL ANCILLARY	174,472.37	757.00
TOTAL ACCOMODATIONS	57,651.00	25,154.00
TOTAL CHARGES	232,123.37	25,911.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,276,429.38	ADJUSTMENTS	429,187.26
COVERED CHARGES	19,168,574.02	CONTRACTUAL ALLOW	17,034,060.88
NON-COVERD CHARGES	4,107,855.36	TOTAL MEDICAID LIAB	2,134,513.14
		LESS: COB	63,989.50
		LESS: COPAYMENT	5,491.68
		REIMBURSEMENT	2,065,031.96
		ALL OTHER	1,787,258.79
		FEE SCHEDULE-LAB	155,984.82
		INJECTABLE DRUGS	121,788.35

TOTAL NUMBER OF CLAIMS 4,459

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,126.72	171.60	OTHER LAB	271,654.00	0.00
MED/SURG SUPPLY	360,276.16	59,475.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	701,305.00	122,268.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,703,778.00	617,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,051.00	41,650.61	FEE SCHEDULE LAB	2,496,895.00	174,692.00
EKG/ECG	340,667.00	9,746.00	MRI SERVICES	380,708.00	54,898.00
IV THERAPY	178,490.00	724.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	997,173.00	467,116.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,953.00	1,713.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118,320.00	62,629.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	231,749.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	271,968.00	96,102.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,632,072.00	252,723.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	368,685.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	841,108.46	620,137.09
RADIOLOGY THERAPEUTIC	690,140.00	696,705.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	475.00	7,500.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,800.00	7,536.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	36,282.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63,286.00	55,286.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,521.67	104,999.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	549,972.00	199,609.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,706.00	18,810.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	186,612.00	257,818.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	449,291.00	127,839.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	336,728.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	403,063.01	13,637.25			

TOTAL ANCILLARY	19,168,574.02	4,107,855.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,168,574.02	4,107,855.36

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	365,522.23	ADJUSTMENTS	0.00
COVERED CHARGES	229,125.16	CONTRACTUAL ALLOW	137,040.78
NON-COVERD CHARGES	136,397.07	TOTAL MEDICAID LIAB	92,084.38
		LESS: COB	92,042.38
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 72

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,622.10	0.00	OTHER LAB	4,392.00	0.00
MED/SURG SUPPLY	900.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,876.00	1,088.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,874.00	85,717.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	683.02	FEE SCHEDULE LAB	43,317.00	1,320.00
EKG/ECG	4,873.00	0.00	MRI SERVICES	5,708.00	14,066.00
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	3,608.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	349.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,647.00	1,980.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,483.61	12,622.03
RADIOLOGY THERAPEUTIC	1,607.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	935.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	611.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	720.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,924.00	12,555.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,782.00	629.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,360.00	3,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,376.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,426.45	0.00			

TOTAL ANCILLARY	229,125.16	136,397.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,125.16	136,397.07

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	380,701.06	ADJUSTMENTS	379.58
COVERED CHARGES	338,487.20	CONTRACTUAL ALLOW	329,533.96
NON-COVERD CHARGES	42,213.86	TOTAL MEDICAID LIAB	8,953.24
		LESS: COB	786.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	7,924.24
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,442.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,003.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,131.00	2,943.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,295.00	28,591.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58,008.00	2,475.00
EKG/ECG	4,430.00	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	208,989.00	2,962.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,689.89	593.86
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,499.00	4,649.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	338,487.20	42,213.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338,487.20	42,213.86

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,413.57	ADJUSTMENTS	0.00
COVERED CHARGES	55,041.57	CONTRACTUAL ALLOW	49,147.04
NON-COVERD CHARGES	19,372.00	TOTAL MEDICAID LIAB	5,894.53
		LESS: COB	5,879.53
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	617.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,680.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,043.00	15,820.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,574.00	314.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,669.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,513.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,124.00	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,984.00	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	1,719.76	502.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,179.00	0.00			

TOTAL ANCILLARY	55,041.57	19,372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,041.57	19,372.00

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

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,536,696.58	ADJUSTMENTS	12,276.88
COVERED CHARGES	1,446,250.08	CONTRACTUAL ALLOW	1,292,226.58
NON-COVERD CHARGES	90,446.50	TOTAL MEDICAID LIAB	154,023.50
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	153,759.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,266.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	614.00	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	2,666.00	465.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,155.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	990.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,290,074.95	88,605.50
RADIOLOGY THERAPEUTIC	32,720.00	1,376.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	72,764.00	0.00			

TOTAL ANCILLARY	1,446,250.08	90,446.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,446,250.08	90,446.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	111,788,803.21	ADJUSTMENTS	4,907,100.95
COVERED CHARGES	100,876,876.11	CONTRACTUAL ALLOW	69,987,064.07
NON-COVERD CHARGES	10,911,927.10	TOTAL MEDICAID LIAB	30,889,812.04
		LESS: COB	485,202.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,404,609.66

TOTAL NUMBER OF ADMISSIONS 2,262

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,715	0	16,428,195.00	1,990,504.00
ROUTINE NURSERY	1,647	0	2,579,708.00	389,281.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,362	0	19,007,903.00	2,379,785.00
SPECIAL CARE SERVICES				
CCU	288	0	1,747,645.00	24,572.00
ICU	1,813	0	9,881,834.00	1,296,173.00
NICU	207	0	750,780.00	260,640.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,308	0	12,380,259.00	1,581,385.00
TOTAL ACCOMODATIONS	15,670	0	31,388,162.00	3,961,170.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,928,170.49	406,669.40	OTHER LAB	482,375.00	5,616.00
MED/SURG SUPPLY	4,201,344.25	212,023.11	RECREATIONAL THERAPY	2,641.00	0.00
LABORATORY-GENERAL	14,236,939.00	574,343.12	EDUCATION & TRAINING	590.00	0.00
RADIOLOGY-DIAGNOSTIC	1,224,080.78	52,330.04	OTHER THERAPEUTIC SVC	0.00	304,716.50
CT SCAN	2,949,398.00	40,398.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,069,870.50	34,228.03	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	492,399.00	5,775.00	MRI SERVICES	1,132,296.00	17,916.00
IV THERAPY	2,063.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,023,777.00	102,733.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,003,098.00	7,201.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,351,468.08	408,351.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,041,412.00	10,780.00	AMBULANCE	0.00	0.00
GI SERVICES	568,012.00	10,429.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,582,924.00	5,085.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	971,396.00	7,076.00	DRUG-SPECIFIC/HOME IV	0.00	95,114.32
LABORATORY PATHOLOGIC	670,149.00	13,946.00	INJECTABLE DRUGS	9,088,917.31	3,117,331.05
RADIOLOGY THERAPEUTIC	175,072.00	6,768.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	458,200.24	20,615.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	201,339.47	7,576.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,381,445.00	164,137.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,586.00	335.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,153,493.74	9,296.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	222,240.00
OTHER IMAGING SERVICE	347,569.00	442,308.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,342,335.25	431,863.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,351.00	146,727.00			
AUDIOLOGY	15,182.00	0.00			
CARDIOLOGY	2,832,985.00	64,985.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	333,910.00	1,628.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	88,925.00	216.00			

TOTAL ANCILLARY	69,488,714.11	6,950,757.10
TOTAL ACCOMODATIONS	31,388,162.00	3,961,170.00
TOTAL CHARGES	100,876,876.11	10,911,927.10

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 09/01/17 THROUGH 08/31/18
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	2017278046530	09/27/17 - 09/29/17	10/09/17	0.00	8,958.00	0.00	0.00	0.00
615	2017285072718	09/25/17 - 09/30/17	10/16/17	0.00	8,958.00	0.00	0.00	0.00
615	2017297049425	10/09/17 - 10/15/17	10/30/17	0.00	8,958.00	0.00	0.00	0.00
615	2017300066139	09/25/17 - 10/05/17	11/06/17	0.00	2,698.00	0.00	0.00	0.00
615	2017304062699	10/03/17 - 10/24/17	11/06/17	0.00	2,698.00	0.00	0.00	0.00
615	2017310036245	10/20/17 - 10/31/17	11/13/17	0.00	5,396.00	0.00	0.00	0.00
615	2017346066915	12/05/17 - 12/06/17	12/18/17	0.00	8,958.00	0.00	0.00	0.00
614	2318025000051	12/13/17 - 12/20/17	02/12/18	0.00	2,698.00	0.00	1,393.41	0.00
615	2018046070861	02/06/18 - 02/10/18	02/19/18	0.00	8,958.00	0.00	0.00	0.00
615	2018050024364	01/13/18 - 01/30/18	02/26/18	0.00	8,958.00	0.00	0.00	0.00
615	2018050024905	02/04/18 - 02/14/18	02/26/18	0.00	8,958.00	0.00	0.00	0.00
615	2018053091279	01/14/18 - 02/05/18	03/05/18	0.00	8,958.00	0.00	0.00	0.00
615	2018061090869	02/04/18 - 02/25/18	03/12/18	0.00	8,958.00	0.00	0.00	0.00
615	2018086070185	03/14/18 - 03/22/18	04/02/18	0.00	2,698.00	0.00	0.00	0.00
615	2018103070422	04/05/18 - 04/07/18	04/23/18	0.00	8,958.00	0.00	0.00	0.00
614	2318127000032	01/27/18 - 02/12/18	05/21/18	0.00	2,698.00	0.00	5,562.03	0.00
615	5918130001930	12/10/17 - 03/23/18	05/14/18	0.00	7,177.00	0.00	0.00	0.00
615	2218169000539	01/03/18 - 02/09/18	06/25/18	0.00	5,396.00	0.00	0.00	0.00
615	2018173066831	06/13/18 - 06/17/18	07/02/18	0.00	2,698.00	0.00	0.00	0.00
615	2218184005912	04/24/18 - 04/30/18	07/09/18	0.00	2,698.00	0.00	0.00	0.00
615	2018225039970	07/30/18 - 08/08/18	08/20/18	0.00	4,479.00	0.00	0.00	0.00
614	2318239000239	06/27/18 - 07/02/18	09/10/18	0.00	3,221.00	0.00	1,182.52	0.00
615	2018240090543	08/17/18 - 08/23/18	09/10/18	0.00	8,958.00	0.00	0.00	0.00
614	2318242000227	06/20/18 - 07/10/18	09/17/18	0.00	4,479.00	0.00	3,583.73	0.00
615	2018244032506	08/22/18 - 08/25/18	09/10/18	0.00	8,958.00	0.00	0.00	0.00
615	2018249100813	08/18/18 - 08/31/18	09/10/18	0.00	4,479.00	0.00	0.00	0.00
614	2018262075325	05/01/18 - 05/09/18	09/24/18	0.00	3,221.00	0.00	0.00	0.00
615	2018269051121	08/16/18 - 09/08/18	10/01/18	0.00	8,958.00	0.00	0.00	0.00
614	2018282096412	06/06/18 - 06/22/18	10/15/18	0.00	2,698.00	0.00	0.00	0.00
614	5218297000135	06/05/18 - 09/01/18	10/29/18	0.00	8,958.00	0.00	0.00	0.00
615	5218309000369	06/07/18 - 07/22/18	11/12/18	0.00	2,698.00	0.00	0.00	0.00
615	2019108076167	06/14/18 - 06/20/18	04/22/19	0.00	8,958.00	0.00	0.00	0.00
614	5219108001721	02/27/18 - 04/11/18	04/22/19	0.00	2,698.00	0.00	0.00	0.00
615	2019136087038	07/15/18 - 07/17/18	05/20/19	0.00	8,958.00	0.00	0.00	0.00
615	2219141011903	02/16/18 - 03/23/18	05/27/19	0.00	2,698.00	0.00	0.00	0.00
615	2019150134464	08/06/18 - 01/02/19	06/03/19	0.00	2,428.00	0.00	0.00	0.00
614	2219234014188	07/27/18 - 09/13/18	08/26/19	0.00	8,958.00	0.00	0.00	0.00
TOTAL				0.00	222,240.00	0.00	11,721.69	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	628,533.25	ADJUSTMENTS	0.00
COVERED CHARGES	611,853.25	CONTRACTUAL ALLOW	248,783.70
NON-COVERD CHARGES	16,680.00	TOTAL MEDICAID LIAB	363,069.55
		LESS: COB	363,069.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	99	0	142,670.00	12,760.00
ROUTINE NURSERY	7	0	8,400.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	106	0	151,070.00	12,760.00
SPECIAL CARE SERVICES				
CCU	3	0	18,429.00	0.00
ICU	4	0	24,572.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	43,001.00	0.00
TOTAL ACCOMODATIONS	113	0	194,071.00	12,760.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,606.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,722.12	194.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,880.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,177.40	0.00	OTHER THERAPEUTIC SVC	0.00	2,641.00
CT SCAN	15,097.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,064.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,926.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,833.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	90,774.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,841.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,599.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,683.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,565.00	0.00	INJECTABLE DRUGS	62,941.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,480.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,524.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,940.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	134.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,320.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	777.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,206.31	851.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,514.00	234.00			
AUDIOLOGY	278.00	0.00			
CARDIOLOGY	29,660.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	417,782.25	3,920.00
TOTAL ACCOMODATIONS	194,071.00	12,760.00
TOTAL CHARGES	611,853.25	16,680.00

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

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,474,750.17	ADJUSTMENTS	895,092.55
COVERED CHARGES	29,250,685.93	CONTRACTUAL ALLOW	22,747,504.56
NON-COVERD CHARGES	11,224,064.24	TOTAL MEDICAID LIAB	6,503,181.37
		LESS: COB	7,626.98
		LESS: COPAYMENT	19,727.79
		REIMBURSEMENT	6,475,826.60
		ALL OTHER	4,269,056.89
		FEE SCHEDULE-LAB	627,195.49
		INJECTABLE DRUGS	1,579,574.22

TOTAL NUMBER OF CLAIMS 11,056

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	532,905.99	519,352.44	OTHER LAB	334,958.00	3,744.00
MED/SURG SUPPLY	771,323.72	40,618.00	RECREATIONAL THERAPY	5,282.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	885,624.84	77,371.16	OTHER THERAPEUTIC SVC	230.00	191,762.00
CT SCAN	2,338,825.00	1,124,219.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,953.00	42,224.10	FEE SCHEDULE LAB	6,963,437.00	885,261.00
EKG/ECG	408,023.00	11,319.00	MRI SERVICES	976,179.00	539,752.00
IV THERAPY	1,252,863.00	25,131.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,234,417.50	1,089,587.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,554.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	275,088.00	48,575.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	568,866.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,875.00	187,237.00	CAST ROOM	903.00	0.00
EMERGENCY ROOM	4,241,253.00	101,312.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	617,092.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,590,809.61	3,049,297.64
RADIOLOGY THERAPEUTIC	406,267.00	325,274.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	19,169.12	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	690.00	14,523.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	282,962.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,318.00	12,216.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,094.27	524,240.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	97,674.00
OTHER IMAGING SERVICE	707,686.00	931,180.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	611,172.00	156,441.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	520,201.00	372,034.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	820,583.00	351,460.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,369.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	909,843.00	200,128.00			

TOTAL ANCILLARY	29,250,685.93	11,224,064.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,250,685.93	11,224,064.24

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 09/01/17 THROUGH 08/31/18
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	2017283093673	10/04/17 - 10/04/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017342062087	09/05/17 - 09/05/17	12/18/17	0.00	4,479.00	0.00	0.00	0.00
615	2017342062087	09/05/17 - 09/05/17	12/18/17	0.00	4,479.00	0.00	0.00	0.00
615	2017352023586	12/12/17 - 12/12/17	12/25/17	0.00	4,479.00	0.00	0.00	0.00
615	2017352023586	12/12/17 - 12/12/17	12/25/17	0.00	4,479.00	0.00	0.00	0.00
615	2018008022629	01/02/18 - 01/02/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018010063309	01/05/18 - 01/05/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018010063309	01/05/18 - 01/05/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018018073249	01/10/18 - 01/10/18	01/22/18	0.00	4,479.00	0.00	0.00	0.00
615	2018025097127	01/03/18 - 01/03/18	01/29/18	0.00	4,479.00	0.00	0.00	0.00
615	2018025097127	01/03/18 - 01/03/18	01/29/18	0.00	4,479.00	0.00	0.00	0.00
615	2018058045666	02/21/18 - 02/21/18	03/05/18	0.00	2,698.00	0.00	0.00	0.00
615	2018058045666	02/21/18 - 02/21/18	03/05/18	0.00	4,479.00	0.00	0.00	0.00
615	2218093009288	03/07/18 - 03/07/18	04/09/18	0.00	4,479.00	0.00	0.00	0.00
615	2218093009288	03/07/18 - 03/07/18	04/09/18	0.00	4,479.00	0.00	0.00	0.00
615	5918163000425	05/22/18 - 05/22/18	06/18/18	0.00	4,479.00	0.00	0.00	0.00
615	2018178078549	06/12/18 - 06/12/18	07/02/18	0.00	4,479.00	0.00	0.00	0.00
615	2018178078549	06/12/18 - 06/12/18	07/02/18	0.00	4,479.00	0.00	0.00	0.00
615	2018193073618	04/16/18 - 04/16/18	07/16/18	0.00	4,479.00	0.00	0.00	0.00
615	2018193073618	04/16/18 - 04/16/18	07/16/18	0.00	4,479.00	0.00	0.00	0.00
615	2218247005031	05/25/18 - 05/25/18	09/10/18	0.00	2,698.00	0.00	0.00	0.00
615	5919064000148	08/06/18 - 08/06/18	03/11/19	0.00	4,479.00	0.00	0.00	0.00
615	5919064000148	08/06/18 - 08/06/18	03/11/19	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	97,674.00	0.00	0.00	0.00

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,030,110.99	ADJUSTMENTS	0.00
COVERED CHARGES	427,978.33	CONTRACTUAL ALLOW	-24,949.35
NON-COVERD CHARGES	602,132.66	TOTAL MEDICAID LIAB	452,927.68
		LESS: COB	452,469.09
		LESS: COPAYMENT	458.59
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 197

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,814.33	18,233.07	OTHER LAB	6,552.00	86.00
MED/SURG SUPPLY	19,869.48	57.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,246.00	6,121.08	OTHER THERAPEUTIC SVC	0.00	5,282.00
CT SCAN	7,870.00	51,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	108,555.00	10,690.00
EKG/ECG	1,540.00	308.00	MRI SERVICES	0.00	17,916.00
IV THERAPY	40,551.00	2,434.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,997.00	107,021.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,454.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,716.00	136.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,860.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,021.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,839.00	2,059.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,918.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	14,114.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,704.52	252,789.11
RADIOLOGY THERAPEUTIC	6,425.00	360.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	90.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	672.00	56,397.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,043.00	28,374.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,449.00	1,731.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	7,555.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,129.00	4,287.00			
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	16,774.00	9,571.00			

TOTAL ANCILLARY	427,978.33	602,132.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	427,978.33	602,132.66

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	268,740.21	ADJUSTMENTS	2,960.60
COVERED CHARGES	243,872.35	CONTRACTUAL ALLOW	229,607.56
NON-COVERD CHARGES	24,867.86	TOTAL MEDICAID LIAB	14,264.79
		LESS: COB	0.00
		LESS: COPAYMENT	630.00
		REIMBURSEMENT	13,634.79

TOTAL NUMBER OF CLAIMS 246

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,194.40	1,202.80	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	2,041.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,440.00	6,292.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,027.00	3,028.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,515.00	2,617.00
EKG/ECG	6,006.00	154.00	MRI SERVICES	2,698.00	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	4,492.00	336.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,665.00	572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,668.95	359.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	90.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,112.00	7,174.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,250.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	591.00	793.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	486.00	0.00			

TOTAL ANCILLARY	243,872.35	24,867.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	243,872.35	24,867.86

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,242.08	ADJUSTMENTS	0.00
COVERED CHARGES	10,004.08	CONTRACTUAL ALLOW	4,038.67
NON-COVERD CHARGES	238.00	TOTAL MEDICAID LIAB	5,965.41
		LESS: COB	5,953.41
		LESS: COPAYMENT	12.00
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	668.00	186.00	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	2,760.00	52.00
EKG/ECG	154.00	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	4,745.00	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	52.08	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,004.08	238.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,004.08	238.00

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

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,074,200.87	ADJUSTMENTS	165,751.62
COVERED CHARGES	5,434,211.98	CONTRACTUAL ALLOW	3,910,194.94
NON-COVERD CHARGES	639,988.89	TOTAL MEDICAID LIAB	1,524,017.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,954.59
		REIMBURSEMENT	1,522,062.45

TOTAL NUMBER OF CLAIMS 248

GEORGIA 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,837.63	1,775.83	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72,859.78	4,866.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,055.08	11,837.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,102.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,224.00	FEE SCHEDULE LAB	350,736.00	28,055.00
EKG/ECG	924.00	154.00	MRI SERVICES	0.00	3,221.00
IV THERAPY	470,343.00	11,550.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	523,765.00	29,052.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	402.00	136.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,698.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	531.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,275,777.49	438,298.98
RADIOLOGY THERAPEUTIC	134,478.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,981.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,967.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	513.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	108,246.00	78,798.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	103.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,067.00	11,382.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,325.00	94.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,880.00	2,200.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205,018.00	6,884.00			

TOTAL ANCILLARY	5,434,211.98	639,988.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,434,211.98	639,988.89

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,677.40	ADJUSTMENTS	0.00
COVERED CHARGES	57,502.56	CONTRACTUAL ALLOW	24,132.32
NON-COVERD CHARGES	174.84	TOTAL MEDICAID LIAB	33,370.24
		LESS: COB	33,352.24
		LESS: COPAYMENT	18.00
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	395.88	174.84	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54.00	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	930.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,834.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	46,992.68	0.00
RADIOLOGY THERAPEUTIC	3,296.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	57,502.56	174.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,502.56	174.84

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,476,564.17	ADJUSTMENTS	26,066.54
COVERED CHARGES	5,395,259.65	CONTRACTUAL ALLOW	3,234,194.35
NON-COVERD CHARGES	81,304.52	TOTAL MEDICAID LIAB	2,161,065.30
		LESS: COB	14,652.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,146,412.68

TOTAL NUMBER OF ADMISSIONS 262

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	717	0	533,126.00	15,740.00
ROUTINE NURSERY	40	0	30,000.00	12,315.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	42.50
TOTAL ROUTINE	757	0	563,126.00	28,097.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	376	0	592,250.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	376	0	592,250.00	0.00
TOTAL ACCOMODATIONS	1,133	0	1,155,376.00	28,097.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356,335.10	0.00	OTHER LAB	26,281.00	0.00
MED/SURG SUPPLY	325,794.49	59.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	989,087.55	0.00	EDUCATION & TRAINING	4,720.00	0.00
RADIOLOGY-DIAGNOSTIC	85,957.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	367,281.00	2,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,989.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,032.00	0.00	MRI SERVICES	82,693.00	0.00
IV THERAPY	90,954.57	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290,462.78	158.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,938.04	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	430,137.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,695.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,283.97	0.00	SPECIAL SERVICES	0.00	6,475.00
RECOVERY ROOM	26,004.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,624.71	0.00	INJECTABLE DRUGS	384,252.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,712.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	28,243.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	61,250.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,348.00	2,360.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,243.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,318.00
OTHER IMAGING SERVICE	23,590.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,210.50	27,197.82			
ONCOLOGY	170.00	0.00			
NUCLEAR MEDICINE	5,411.00	768.00			
AUDIOLOGY	4,535.49	0.00			
CARDIOLOGY	101,888.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	757.10	0.00			

TOTAL ANCILLARY	4,239,883.65	53,207.02
TOTAL ACCOMODATIONS	1,155,376.00	28,097.50
TOTAL CHARGES	5,395,259.65	81,304.52

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 07/01/17 THROUGH 06/30/18
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	2017262041214	08/24/17 - 09/05/17	09/25/17	0.00	3,379.00	0.00	0.00	0.00
614	2018072067813	01/21/18 - 02/02/18	03/19/18	0.00	3,379.00	0.00	0.00	0.00
614	2018095072622	02/28/18 - 03/03/18	04/09/18	0.00	3,280.00	0.00	0.00	0.00
614	2018134026104	12/15/17 - 12/20/17	05/21/18	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	13,318.00	0.00	0.00	0.00

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

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,085.75	ADJUSTMENTS	0.00
COVERED CHARGES	4,085.75	CONTRACTUAL ALLOW	1,235.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,849.80
		LESS: COB	2,849.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	478.00	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	478.00	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	478.00	0.00

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

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	294.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	963.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	192.00	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	271.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	651.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	869.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,607.75	0.00
TOTAL ACCOMODATIONS	478.00	0.00
TOTAL CHARGES	4,085.75	0.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,238,926.89	ADJUSTMENTS	276,646.68
COVERED CHARGES	5,419,669.63	CONTRACTUAL ALLOW	4,341,563.93
NON-COVERD CHARGES	819,257.26	TOTAL MEDICAID LIAB	1,078,105.70
		LESS: COB	494.26
		LESS: COPAYMENT	4,082.62
		REIMBURSEMENT	1,073,528.82
		ALL OTHER	796,237.50
		FEE SCHEDULE-LAB	150,095.03
		INJECTABLE DRUGS	127,196.29

TOTAL NUMBER OF CLAIMS 3,793

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,705.93	29,342.45	OTHER LAB	150,610.23	2,116.00
MED/SURG SUPPLY	144,684.37	11,811.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	161.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	232,031.37	26,367.19	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	877,392.00	154,645.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,262.00	5,388.00	FEE SCHEDULE LAB	1,447,398.13	81,059.92
EKG/ECG	60,914.00	426.00	MRI SERVICES	161,449.00	23,417.00
IV THERAPY	198,167.87	45,056.68	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	415,593.28	88,622.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,558.78	182.77	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,529.39	5,912.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,989.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	690,807.67	15,178.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,742.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391,918.77	237,110.19
RADIOLOGY THERAPEUTIC	15,273.38	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	611.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	367.00	2,124.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,750.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84,650.95	12,455.54	TRAUMA RESPONSE	0.00	1,133.87
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,421.75	13,501.95
LITHOTRIPSY	23,290.68	0.00	NO CC/INVALID REV CODE	0.00	6,921.00
OTHER IMAGING SERVICE	121,519.00	14,451.00			
BLOOD	0.00	2,222.05			
BLOOD STORAGE & PRO.	4,371.23	3,226.86			
ONCOLOGY	7,846.00	2,722.00			
NUCLEAR MEDICINE	71,819.85	19,924.00			
AUDIOLOGY	238.71	0.00			
CARDIOLOGY	51,132.00	8,574.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,018.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,967.29	841.41			

TOTAL ANCILLARY	5,419,669.63	819,257.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,419,669.63	819,257.26

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 07/01/17 THROUGH 06/30/18
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
525	5917262001649	07/06/17 - 07/06/17	09/25/17	0.00	262.00	0.00	0.00	0.00
614	2018025067193	12/28/17 - 12/28/17	01/29/18	0.00	3,280.00	0.00	0.00	0.00
614	2018096018899	03/09/18 - 03/09/18	04/09/18	0.00	3,379.00	0.00	0.00	0.00
TOTAL				0.00	6,921.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,324.92	ADJUSTMENTS	0.00
COVERED CHARGES	59,587.23	CONTRACTUAL ALLOW	13,778.76
NON-COVERD CHARGES	50,737.69	TOTAL MEDICAID LIAB	45,808.47
		LESS: COB	45,787.16
		LESS: COPAYMENT	21.31
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.04	920.23	OTHER LAB	2,987.00	0.00
MED/SURG SUPPLY	1,747.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,310.00	228.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,326.00	4,413.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,196.32	2,674.00
EKG/ECG	852.00	0.00	MRI SERVICES	2,394.00	3,379.00
IV THERAPY	1,021.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,991.88	4,991.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302.06	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,427.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	599.15	29,034.58
RADIOLOGY THERAPEUTIC	726.68	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	3,280.00
OTHER IMAGING SERVICE	4,520.00	1,697.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	820.00	120.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	700.95	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	59,587.23	50,737.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,587.23	50,737.69

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

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 07/01/17 THROUGH 06/30/18
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	2018078020972	02/21/18 - 02/21/18	03/26/18	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	3,280.00	0.00	0.00	0.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,408.96	ADJUSTMENTS	482.46
COVERED CHARGES	227,459.18	CONTRACTUAL ALLOW	215,320.20
NON-COVERD CHARGES	24,949.78	TOTAL MEDICAID LIAB	12,138.98
		LESS: COB	0.00
		LESS: COPAYMENT	438.00
		REIMBURSEMENT	11,700.98
		TOTAL NUMBER OF CLAIMS	217

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,306.51	627.80	OTHER LAB	616.00	0.00
MED/SURG SUPPLY	3,856.84	134.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,366.00	2,698.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,926.00	14,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,506.98	4,773.00
EKG/ECG	4,828.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,516.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,570.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	868.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	542.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,213.23	515.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	599.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,107.53	659.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.00	70.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	135.70	57.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,282.00	285.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	888.82	921.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,228.07	0.00			

TOTAL ANCILLARY	227,459.18	24,949.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	227,459.18	24,949.78

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	309.00	ADJUSTMENTS	0.00
COVERED CHARGES	150.00	CONTRACTUAL ALLOW	25.38
NON-COVERD CHARGES	159.00	TOTAL MEDICAID LIAB	124.62
		LESS: COB	124.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	159.00	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	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	150.00	159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	150.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	461,283.46	ADJUSTMENTS	17,245.47
COVERED CHARGES	390,870.97	CONTRACTUAL ALLOW	287,290.15
NON-COVERD CHARGES	70,412.49	TOTAL MEDICAID LIAB	103,580.82
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	103,454.82
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,355.37	531.97	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,802.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,376.00	2,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,043.00	666.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,075.73	1,250.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	336,253.53	65,223.52
RADIOLOGY THERAPEUTIC	18,980.84	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	984.00	553.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	390,870.97	70,412.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	390,870.97	70,412.49

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,629,397.41	ADJUSTMENTS	141,673.03
COVERED CHARGES	2,107,505.00	CONTRACTUAL ALLOW	1,477,902.87
NON-COVERD CHARGES	521,892.41	TOTAL MEDICAID LIAB	629,602.13
		LESS: COB	10,519.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	619,082.20

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	372	0	391,716.00	499,555.83
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	372	0	391,716.00	499,555.83
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	111	0	306,316.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	306,316.80	0.00
TOTAL ACCOMODATIONS	483	0	698,032.80	499,555.83

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,734.20	0.00	OTHER LAB	1,662.50	0.00
MED/SURG SUPPLY	186,989.74	1,839.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	139,263.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,839.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,327.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,581.63	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,836.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,453.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	578,445.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,396.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,507.00	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	1,184.00	0.00	INJECTABLE DRUGS	135,646.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,433.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,252.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,450.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	197.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,676.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,090.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,300.00	19,047.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,692.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,561.58	0.00			

TOTAL ANCILLARY	1,409,472.20	22,336.58
TOTAL ACCOMODATIONS	698,032.80	499,555.83
TOTAL CHARGES	2,107,505.00	521,892.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,290,572.86	ADJUSTMENTS	895,528.53
COVERED CHARGES	52,528,630.07	CONTRACTUAL ALLOW	35,689,691.24
NON-COVERD CHARGES	3,761,942.79	TOTAL MEDICAID LIAB	16,838,938.83
		LESS: COB	247,422.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,591,516.51

TOTAL NUMBER OF ADMISSIONS 2,132

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,184	0	7,187,116.65	2,020,796.54
ROUTINE NURSERY	1,657	0	2,703,703.00	693,804.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,841	0	9,890,819.65	2,714,600.54
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,465	0	3,981,384.49	0.00
NICU	24	0	84,000.00	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	1,489	0	4,065,384.49	0.00
TOTAL ACCOMODATIONS	10,330	0	13,956,204.14	2,714,600.54

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,510,658.95	5,246.60	OTHER LAB	422,319.00	0.00
MED/SURG SUPPLY	1,077,470.45	1,256.82	RECREATIONAL THERAPY	43,488.75	0.00
LABORATORY-GENERAL	5,711,390.93	3,904.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	947,397.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,683,298.00	127,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,062,079.27	402.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	517,760.68	0.00	MRI SERVICES	383,265.00	0.00
IV THERAPY	930,573.90	4,831.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,726,596.92	4,054.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	435,344.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,688,641.85	4,323.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	613,556.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	173,796.00	3,272.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,104,907.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,453,516.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	400.90
LABORATORY PATHOLOGIC	260,626.85	0.00	INJECTABLE DRUGS	4,227,800.16	53,250.80
RADIOLOGY THERAPEUTIC	250,139.39	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	820,530.24	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	414,997.34	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	151,636.00	237,896.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	55,295.07	2,395.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	701,704.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,124.00
OTHER IMAGING SERVICE	398,451.14	4,862.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	425,802.12	549,212.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	344,054.69	30,555.00			
AUDIOLOGY	120,831.92	0.00			
CARDIOLOGY	1,051,088.12	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	118,663.31	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	744,743.93	720.00			

TOTAL ANCILLARY	38,572,425.93	1,047,342.25
TOTAL ACCOMODATIONS	13,956,204.14	2,714,600.54
TOTAL CHARGES	52,528,630.07	3,761,942.79

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 07/01/17 THROUGH 06/30/18
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	2017219025318	07/30/17 - 08/02/17	08/14/17	0.00	193.00	0.00	0.00	0.00
948	2017248096992	08/30/17 - 09/01/17	09/11/17	0.00	193.00	0.00	0.00	0.00
948	2017264096644	09/13/17 - 09/16/17	09/25/17	0.00	193.00	0.00	0.00	0.00
948	2017272070746	09/12/17 - 09/15/17	10/09/17	0.00	386.00	0.00	0.00	0.00
948	2017283093964	10/04/17 - 10/06/17	10/16/17	0.00	193.00	0.00	0.00	0.00
948	2017320085086	11/04/17 - 11/10/17	11/20/17	0.00	193.00	0.00	0.00	0.00
-1	2017321069135	11/09/17 - 11/11/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017324040474	11/13/17 - 11/15/17	11/27/17	0.00	193.00	0.00	0.00	0.00
948	2217326012271	10/15/17 - 10/24/17	11/27/17	0.00	193.00	0.00	0.00	0.00
948	2017331030055	11/14/17 - 11/17/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017332079514	11/08/17 - 11/09/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017334079414	11/19/17 - 11/23/17	12/04/17	0.00	386.00	0.00	0.00	0.00
948	2217362005201	10/30/17 - 10/31/17	01/01/18	0.00	193.00	0.00	0.00	0.00
948	2018003063766	12/26/17 - 12/27/17	01/08/18	0.00	193.00	0.00	0.00	0.00
948	2018008024554	01/01/18 - 01/03/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018008024644	12/27/17 - 01/04/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018009067157	01/03/18 - 01/05/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018009067186	12/22/17 - 12/31/17	01/15/18	0.00	193.00	0.00	0.00	0.00
948	2018009068273	01/03/18 - 01/05/18	01/15/18	0.00	193.00	0.00	0.00	0.00
948	2018022031038	11/27/17 - 11/29/17	01/29/18	0.00	193.00	0.00	0.00	0.00
948	2018026074691	01/18/18 - 01/22/18	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2218032003588	01/07/18 - 01/10/18	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2018032097159	11/02/17 - 11/04/17	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2018040074619	02/03/18 - 02/06/18	02/19/18	0.00	193.00	0.00	0.00	0.00
-1	2318043000242	12/08/17 - 12/19/17	02/26/18	0.00	193.00	0.00	2,091.17	0.00
948	2218064002233	02/20/18 - 02/26/18	03/12/18	0.00	193.00	0.00	0.00	0.00
948	2018066085157	02/27/18 - 03/02/18	03/12/18	0.00	193.00	0.00	0.00	0.00
-1	2318072000127	11/18/17 - 11/20/17	03/26/18	0.00	193.00	0.00	877.82	0.00
948	2018072085528	03/05/18 - 03/09/18	03/19/18	0.00	193.00	0.00	0.00	0.00
948	2018079075350	02/28/18 - 03/04/18	03/26/18	0.00	193.00	0.00	0.00	0.00
948	2218085000780	03/06/18 - 03/08/18	04/02/18	0.00	193.00	0.00	0.00	0.00
948	2018086070848	03/21/18 - 03/22/18	04/02/18	0.00	193.00	0.00	0.00	0.00
948	2018093094909	03/27/18 - 03/30/18	04/09/18	0.00	193.00	0.00	0.00	0.00
948	2018096073607	03/21/18 - 03/23/18	04/16/18	0.00	193.00	0.00	0.00	0.00
948	2018107073226	03/28/18 - 04/02/18	04/23/18	0.00	193.00	0.00	0.00	0.00
948	2018122080677	04/23/18 - 04/28/18	05/07/18	0.00	193.00	0.00	0.00	0.00
948	2018122080830	04/25/18 - 04/28/18	05/07/18	0.00	193.00	0.00	0.00	0.00
948	2018130106622	04/25/18 - 05/03/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2018130106806	05/01/18 - 05/03/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2218131007205	04/25/18 - 04/28/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2018137094609	05/08/18 - 05/10/18	05/21/18	0.00	193.00	0.00	0.00	0.00
948	2018141033111	05/10/18 - 05/15/18	05/28/18	0.00	193.00	0.00	0.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

948	2018150000348	05/16/18 - 05/22/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018150000465	05/18/18 - 05/22/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018150000634	05/20/18 - 05/23/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018151025421	05/08/18 - 05/12/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018151025470	04/12/18 - 04/18/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018165022642	05/30/18 - 06/08/18	06/18/18	0.00	193.00	0.00	0.00	0.00
948	2018166000891	06/04/18 - 06/11/18	06/18/18	0.00	193.00	0.00	0.00	0.00
948	2018170033224	06/11/18 - 06/13/18	06/25/18	0.00	193.00	0.00	0.00	0.00
-1	2318171000266	04/15/18 - 04/21/18	07/02/18	0.00	772.00	0.00	2,663.18	0.00
948	2018172000997	06/08/18 - 06/13/18	06/25/18	0.00	386.00	0.00	0.00	0.00
948	2018177022466	06/15/18 - 06/20/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2018179079209	06/22/18 - 06/25/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2218183000197	05/29/18 - 06/11/18	07/09/18	0.00	193.00	0.00	0.00	0.00
948	2018184093280	06/11/18 - 06/12/18	07/09/18	0.00	193.00	0.00	0.00	0.00
948	2218194003625	06/25/18 - 06/28/18	07/16/18	0.00	193.00	0.00	0.00	0.00
948	2218264003496	04/17/18 - 04/24/18	09/24/18	0.00	193.00	0.00	0.00	0.00
948	2218299014615	04/18/18 - 04/30/18	10/29/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	13,124.00	0.00	5,632.17	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	619,905.28	ADJUSTMENTS	0.00
COVERED CHARGES	603,963.32	CONTRACTUAL ALLOW	259,350.80
NON-COVERD CHARGES	15,941.96	TOTAL MEDICAID LIAB	344,612.52
		LESS: COB	344,612.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	73	0	73,073.00	12,799.15
ROUTINE NURSERY	6	0	14,400.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	79	0	87,473.00	12,799.15
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	14	0	34,011.60	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	34,011.60	0.00
TOTAL ACCOMODATIONS	93	0	121,484.60	12,799.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,272.60	0.00	OTHER LAB	4,480.45	0.00
MED/SURG SUPPLY	8,439.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	62,822.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,476.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,029.00	1,172.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,850.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,130.00	0.00	MRI SERVICES	8,917.00	0.00
IV THERAPY	10,688.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,304.24	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,244.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,792.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,998.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,937.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,139.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,492.00	0.00	INJECTABLE DRUGS	145,371.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,616.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,632.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	572.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,695.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,733.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,482.00	1,351.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,833.75	618.75			
AUDIOLOGY	833.00	0.00			
CARDIOLOGY	4,208.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,460.54	0.00			

TOTAL ANCILLARY	482,478.72	3,142.81
TOTAL ACCOMODATIONS	121,484.60	12,799.15
TOTAL CHARGES	603,963.32	15,941.96

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,419,353.64	ADJUSTMENTS	602,362.19
COVERED CHARGES	19,090,862.18	CONTRACTUAL ALLOW	15,902,215.73
NON-COVERD CHARGES	2,328,491.46	TOTAL MEDICAID LIAB	3,188,646.45
		LESS: COB	5,216.61
		LESS: COPAYMENT	7,874.89
		REIMBURSEMENT	3,175,554.95
		ALL OTHER	2,827,445.20
		FEE SCHEDULE-LAB	245,423.10
		INJECTABLE DRUGS	102,686.65

TOTAL NUMBER OF CLAIMS 6,343

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	327,314.18	766.90	OTHER LAB	482,218.95	23,257.30
MED/SURG SUPPLY	265,335.06	40,515.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,022,843.13	76,934.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,585,992.00	211,933.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	201,886.53	42,008.16	FEE SCHEDULE LAB	2,702,541.46	155,326.76
EKG/ECG	544,625.00	3,912.50	MRI SERVICES	241,850.00	43,924.00
IV THERAPY	921,518.82	55,767.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,556.02	401,134.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162,168.76	44,077.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	346,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	46,203.00	23,865.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,737,017.79	14,782.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	487,521.00	16,400.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	548,912.20	502,713.10
RADIOLOGY THERAPEUTIC	190,446.86	9,656.69	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,742.25	18,233.95	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,521.50	13,112.77	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,516.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,882.00	11,064.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,442.52	112,035.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	772.00
OTHER IMAGING SERVICE	860,313.75	130,729.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,307.00	48,767.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	129,271.00	180,660.75			
AUDIOLOGY	4,448.50	344.25			
CARDIOLOGY	214,036.75	67,770.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,506.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	633,943.90	53,510.74			

TOTAL ANCILLARY	19,090,862.18	2,328,491.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,090,862.18	2,328,491.46

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 07/01/17 THROUGH 06/30/18
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	9818063000326	07/17/17 - 07/17/17	03/12/18	0.00	193.00	0.00	0.00	0.00
-1	2318218000112	01/03/18 - 01/03/18	08/27/18	0.00	193.00	0.00	0.00	0.00
-1	2318218000112	01/04/18 - 01/04/18	08/27/18	0.00	193.00	0.00	0.00	0.00
-1	2218219001070	05/22/18 - 05/22/18	08/20/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	772.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	359,110.66	ADJUSTMENTS	0.00
COVERED CHARGES	261,607.08	CONTRACTUAL ALLOW	120,548.03
NON-COVERD CHARGES	97,503.58	TOTAL MEDICAID LIAB	141,059.05
		LESS: COB	140,979.26
		LESS: COPAYMENT	79.79
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,329.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,348.20	2,939.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,341.00	3,489.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,178.00	10,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,968.18	1,073.90
EKG/ECG	4,851.50	0.00	MRI SERVICES	1,497.00	1,497.00
IV THERAPY	17,030.05	609.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,144.07	29,045.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,506.53	212.57	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,432.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,565.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,842.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,970.40	3,612.90
RADIOLOGY THERAPEUTIC	2,233.96	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	302.45	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,389.60	17,476.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,112.25	12,040.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,948.25	5,391.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,627.00	6,696.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,986.91	1,381.00			

TOTAL ANCILLARY	261,607.08	97,503.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	261,607.08	97,503.58

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	406,535.63	ADJUSTMENTS	703.22
COVERED CHARGES	399,479.23	CONTRACTUAL ALLOW	382,305.65
NON-COVERD CHARGES	7,056.40	TOTAL MEDICAID LIAB	17,173.58
		LESS: COB	0.00
		LESS: COPAYMENT	600.00
		REIMBURSEMENT	16,573.58
		TOTAL NUMBER OF CLAIMS	307

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,627.10	0.00	OTHER LAB	3,654.60	0.00
MED/SURG SUPPLY	270.53	384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,899.00	2,277.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,530.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,233.72	1,562.00
EKG/ECG	3,677.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,656.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	637.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	286,757.15	781.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,546.30	332.90
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,544.50	1,719.50			
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	444.46	0.00			

TOTAL ANCILLARY	399,479.23	7,056.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	399,479.23	7,056.40

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,030.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,465.50	CONTRACTUAL ALLOW	16,625.18
NON-COVERD CHARGES	565.00	TOTAL MEDICAID LIAB	9,840.32
		LESS: COB	9,822.32
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.60	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	1,727.00	496.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,203.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,712.00	69.00
EKG/ECG	1,565.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,122.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	14,457.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	552.70	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,465.50	565.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,465.50	565.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,461,786.40	ADJUSTMENTS	56,201.00
COVERED CHARGES	3,129,719.08	CONTRACTUAL ALLOW	2,702,044.28
NON-COVERD CHARGES	332,067.32	TOTAL MEDICAID LIAB	427,674.80
		LESS: COB	0.00
		LESS: COPAYMENT	839.42
		REIMBURSEMENT	426,835.38

TOTAL NUMBER OF CLAIMS 76

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,355.18	349.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47,232.21	4,343.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,221.00	9,323.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,654.00	10,515.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,725.05	FEE SCHEDULE LAB	108,155.92	5,907.55
EKG/ECG	6,651.25	782.50	MRI SERVICES	0.00	0.00
IV THERAPY	170,844.53	7,703.46	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	217,823.91	36,816.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,884.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,451.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,893,307.60	186,187.90
RADIOLOGY THERAPEUTIC	125,047.38	13,284.24	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	695.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,380.15	5,235.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	183,711.66	21,484.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,468.75	10,502.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,710.00	6,531.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,362.50	4,375.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,228.00	5,454.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,877.55	850.82			

TOTAL ANCILLARY	3,129,719.08	332,067.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,129,719.08	332,067.32

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	102,157.17	ADJUSTMENTS	0.00
COVERED CHARGES	79,593.99	CONTRACTUAL ALLOW	36,806.07
NON-COVERD CHARGES	22,563.18	TOTAL MEDICAID LIAB	42,787.92
		LESS: COB	42,754.92
		LESS: COPAYMENT	33.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,622.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	388.80	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	1,335.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,851.86	779.78	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,034.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	62,743.90	21,341.80
RADIOLOGY THERAPEUTIC	2,617.32	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	441.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	79,593.99	22,563.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,593.99	22,563.18

** END OF REPORT **

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,702,610.22	ADJUSTMENTS	101,022.36
COVERED CHARGES	10,966,562.53	CONTRACTUAL ALLOW	6,481,180.85
NON-COVERD CHARGES	736,047.69	TOTAL MEDICAID LIAB	4,485,381.68
		LESS: COB	51,074.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,434,306.80

TOTAL NUMBER OF ADMISSIONS 526

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,819	0	1,820,819.00	512,654.06
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,819	0	1,820,819.00	512,654.06
SPECIAL CARE SERVICES				
CCU	7	0	9,752.80	0.00
ICU	269	0	772,704.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	276	0	782,457.60	0.00
TOTAL ACCOMODATIONS	2,095	0	2,603,276.60	512,654.06

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	781,391.70	0.00	OTHER LAB	106,112.25	0.00
MED/SURG SUPPLY	161,966.13	226.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,621,474.64	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	269,873.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	545,671.00	2,812.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	124,868.72	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	154,074.25	0.00	MRI SERVICES	63,266.00	0.00
IV THERAPY	447,597.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	428,934.57	1,527.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806,825.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	87,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	46,982.00	1,208.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,627.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	30,530.00	0.00	INJECTABLE DRUGS	722,263.89	0.00
RADIOLOGY THERAPEUTIC	4,634.37	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,033.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,841.33	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	25,424.00	60,836.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,083.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	76,269.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,158.00
OTHER IMAGING SERVICE	87,456.81	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,757.00	141,769.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	144,554.50	13,855.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	224,980.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,651.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	125,474.60	0.00			

TOTAL ANCILLARY	8,363,285.93	223,393.63
TOTAL ACCOMODATIONS	2,603,276.60	512,654.06
TOTAL CHARGES	10,966,562.53	736,047.69

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2018114003102	04/17/18 - 04/19/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2018115068850	03/31/18 - 04/04/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2218117002046	03/24/18 - 03/26/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2018155039426	05/28/18 - 05/30/18	06/11/18	0.00	193.00	0.00	0.00	0.00
948	2018178005802	06/16/18 - 06/21/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2218201001601	05/26/18 - 06/13/18	07/23/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	1,158.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,396.01	ADJUSTMENTS	0.00
COVERED CHARGES	31,930.64	CONTRACTUAL ALLOW	9,625.96
NON-COVERD CHARGES	4,465.37	TOTAL MEDICAID LIAB	22,304.68
		LESS: COB	22,304.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,005.00	1,762.25
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	5,005.00	1,762.25
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	5,005.00	1,762.25

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,416.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	306.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,291.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,406.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	782.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,897.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	655.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,498.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,487.70	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	98.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	174.00	2,703.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,948.80	0.00			

TOTAL ANCILLARY	26,925.64	2,703.12
TOTAL ACCOMODATIONS	5,005.00	1,762.25
TOTAL CHARGES	31,930.64	4,465.37

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,012,297.44	ADJUSTMENTS	337,571.17
COVERED CHARGES	12,158,131.77	CONTRACTUAL ALLOW	10,153,976.87
NON-COVERD CHARGES	854,165.67	TOTAL MEDICAID LIAB	2,004,154.90
		LESS: COB	2,868.03
		LESS: COPAYMENT	3,633.00
		REIMBURSEMENT	1,997,653.87
		ALL OTHER	1,817,733.03
		FEE SCHEDULE-LAB	149,197.72
		INJECTABLE DRUGS	30,723.12

TOTAL NUMBER OF CLAIMS 4,735

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,992.40	661.40	OTHER LAB	211,387.25	0.00
MED/SURG SUPPLY	98,586.97	7,785.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	756,426.50	41,790.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,042,055.00	166,746.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	151,913.02	37,682.86	FEE SCHEDULE LAB	1,839,739.41	76,062.88
EKG/ECG	383,282.81	1,173.75	MRI SERVICES	140,622.00	25,348.00
IV THERAPY	787,937.81	64,385.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	354,406.51	113,683.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79,944.93	5,539.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,957.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,347.00	11,152.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,685,450.06	14,593.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,686.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	243,487.60	37,561.90
RADIOLOGY THERAPEUTIC	45,450.60	18,162.84	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,045.25	10,345.62	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,170.00	2,149.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	12,712.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	883.20	7,186.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,705.74	21,492.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516,258.50	90,452.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,668.00	6,757.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,450.25	44,952.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,635.75	7,934.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	232,389.71	26,167.60			

TOTAL ANCILLARY	12,158,131.77	854,165.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,158,131.77	854,165.67

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	202,172.88	ADJUSTMENTS	0.00
COVERED CHARGES	157,714.55	CONTRACTUAL ALLOW	68,698.43
NON-COVERD CHARGES	44,458.33	TOTAL MEDICAID LIAB	89,016.12
		LESS: COB	88,992.12
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,146.70	0.00	OTHER LAB	1,166.25	0.00
MED/SURG SUPPLY	1,799.00	549.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,692.50	3,142.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,942.00	11,934.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,569.72	998.00
EKG/ECG	3,130.00	0.00	MRI SERVICES	0.00	3,810.00
IV THERAPY	14,210.89	613.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,403.07	4,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	922.64	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,004.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,208.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,921.88	1,547.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,700.90	359.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	98.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	450.00	2,952.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,252.50	12,746.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	157,714.55	44,458.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	157,714.55	44,458.33

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	609,812.29	ADJUSTMENTS	1,126.74
COVERED CHARGES	597,056.82	CONTRACTUAL ALLOW	572,331.34
NON-COVERD CHARGES	12,755.47	TOTAL MEDICAID LIAB	24,725.48
		LESS: COB	0.00
		LESS: COPAYMENT	705.00
		REIMBURSEMENT	24,020.48
		TOTAL NUMBER OF CLAIMS	442

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,695.40	0.00	OTHER LAB	2,332.50	0.00
MED/SURG SUPPLY	1,959.92	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,816.50	3,575.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,275.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87,727.46	1,658.00
EKG/ECG	7,277.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,330.14	612.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,826.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	415,042.65	1,646.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,082.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,288.00	764.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,660.00	800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,665.00	1,248.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,079.00	0.00			

TOTAL ANCILLARY	597,056.82	12,755.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	597,056.82	12,755.47

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,667.53	ADJUSTMENTS	0.00
COVERED CHARGES	20,487.42	CONTRACTUAL ALLOW	8,356.48
NON-COVERD CHARGES	4,180.11	TOTAL MEDICAID LIAB	12,130.94
		LESS: COB	12,118.94
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145.30	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	1,980.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,774.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,029.86	204.61	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,718.31	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	168.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	671.25	2,027.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,487.42	4,180.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,487.42	4,180.11

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,904.80	ADJUSTMENTS	0.00
COVERED CHARGES	79,367.69	CONTRACTUAL ALLOW	67,769.43
NON-COVERD CHARGES	4,537.11	TOTAL MEDICAID LIAB	11,598.26
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,592.26

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,376.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	529.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	292.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,203.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	532.50	FEE SCHEDULE LAB	1,756.00	785.00
EKG/ECG	782.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	408.08	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,318.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,404.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,767.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	403.40	0.00
RADIOLOGY THERAPEUTIC	30,446.29	1,868.05	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	872.00	1,351.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,478.40	0.00			

TOTAL ANCILLARY	79,367.69	4,537.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,367.69	4,537.11

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,594,435.20	ADJUSTMENTS	8,006,543.48
COVERED CHARGES	135,238,434.76	CONTRACTUAL ALLOW	117,767,713.88
NON-COVERD CHARGES	4,356,000.44	TOTAL MEDICAID LIAB	17,470,720.88
		LESS: COB	85,584.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,385,136.50

TOTAL NUMBER OF ADMISSIONS 950

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,200	0	2,251,629.00	1,252,485.28
ROUTINE NURSERY	204	0	230,837.00	105,551.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,404	0	2,482,466.00	1,358,036.28
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2,196	0	7,372,717.00	0.00
NICU	1	0	4,062.00	0.00
PED ICU	3	0	11,172.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	9	0	49,800.00	0.00
BURN UNIT	1,117	0	11,021,386.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,326	0	18,459,137.00	0.00
TOTAL ACCOMODATIONS	5,730	0	20,941,603.00	1,358,036.28

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,242,515.06	408,863.37	OTHER LAB	578,205.32	0.00
MED/SURG SUPPLY	19,991,709.76	255,751.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,256,157.55	16,110.16	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,406,242.95	0.00	OTHER THERAPEUTIC SVC	0.00	1,523.16
CT SCAN	2,454,378.32	512,456.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	941,601.44	439.63	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	467,060.09	0.00	MRI SERVICES	531,088.81	0.00
IV THERAPY	24,913.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,256,883.83	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	261,735.38	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,467,123.58	457.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,638.93	0.00	AMBULANCE	0.00	0.00
GI SERVICES	339,092.53	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,247,785.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,417,770.12	164.50	DRUG-SPECIFIC/HOME IV	0.00	118,336.74
LABORATORY PATHOLOGIC	391,270.95	0.00	INJECTABLE DRUGS	24,419,654.95	65,898.59
RADIOLOGY THERAPEUTIC	103,709.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,359,807.26	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	176,334.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	787,971.45	12,497.76	PATIENT CONVENIENCE	0.00	1,008.72
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,723.52	49,125.66	TRAUMA RESPONSE	0.00	66,902.40
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	906,754.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	517,606.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	666,539.36	1,472,503.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	302,159.71	15,924.31			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,426,275.61	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	125,864.78	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	170,257.13	0.00			

TOTAL ANCILLARY	114,296,831.76	2,997,964.16
TOTAL ACCOMODATIONS	20,941,603.00	1,358,036.28
TOTAL CHARGES	135,238,434.76	4,356,000.44

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 04/01/17 THROUGH 03/31/18
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	2017251089461	05/23/17 - 06/13/17	09/18/17	0.00	0.00	0.00	0.00	0.00
24	2018082082003	09/28/17 - 10/09/17	04/02/18	0.00	0.00	0.00	0.00	0.00
24	2018110068143	03/16/18 - 03/28/18	04/30/18	0.00	0.00	0.00	0.00	0.00
24	2018135062347	01/18/18 - 01/30/18	05/21/18	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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,490.91	ADJUSTMENTS	0.00
COVERED CHARGES	47,705.91	CONTRACTUAL ALLOW	33,498.25
NON-COVERD CHARGES	15,785.00	TOTAL MEDICAID LIAB	14,207.66
		LESS: COB	14,207.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,080.00	15,785.00
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	5,080.00	15,785.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	5,080.00	15,785.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,435.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,298.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,372.63	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	25,657.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	655.59	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,457.19	0.00	INJECTABLE DRUGS	9,609.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140.16	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	42,625.91	0.00
TOTAL ACCOMODATIONS	5,080.00	15,785.00
TOTAL CHARGES	47,705.91	15,785.00

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

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,321,552.28	ADJUSTMENTS	55,420.88
COVERED CHARGES	20,378,328.29	CONTRACTUAL ALLOW	18,822,771.00
NON-COVERD CHARGES	3,943,223.99	TOTAL MEDICAID LIAB	1,555,557.29
		LESS: COB	2,823.33
		LESS: COPAYMENT	5,079.18
		REIMBURSEMENT	1,547,654.78
		ALL OTHER	1,425,406.37
		FEE SCHEDULE-LAB	108,729.47
		INJECTABLE DRUGS	13,518.94

TOTAL NUMBER OF CLAIMS 4,609

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220,420.23	76,857.14	OTHER LAB	84,216.49	0.00
MED/SURG SUPPLY	1,887,236.65	78,870.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	555,466.38	175,041.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,216,981.23	400,755.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	107,940.69	75,214.31	FEE SCHEDULE LAB	1,457,845.10	105,891.58
EKG/ECG	411,819.35	0.00	MRI SERVICES	145,241.14	64,499.94
IV THERAPY	631,562.95	99,504.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,911,289.78	1,455,334.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	345,500.32	20,805.64	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130,905.65	1,402.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,800.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	227,509.39	89,714.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,714,200.83	21,373.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,596,556.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	992.85
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	513,508.45	361,939.80
RADIOLOGY THERAPEUTIC	470,490.22	150,069.78	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,335.80	55,913.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	706.52	2,570.97	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,562.22	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	332,432.21	48,138.46	TRAUMA RESPONSE	0.00	61,851.20
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,346.00	1,481.75
LITHOTRIPSY	59,057.31	61,869.56	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	388,764.00	124,580.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,186.10	7,497.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,311.59	254,983.43			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,372.77	59,858.40			
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	589,324.62	84,650.65			

TOTAL ANCILLARY	20,378,328.29	3,943,223.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,378,328.29	3,943,223.99

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	503,384.33	ADJUSTMENTS	0.00
COVERED CHARGES	320,550.31	CONTRACTUAL ALLOW	212,051.04
NON-COVERD CHARGES	182,834.02	TOTAL MEDICAID LIAB	108,499.27
		LESS: COB	108,467.31
		LESS: COPAYMENT	31.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	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

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,296.61	987.81	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,774.76	675.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,292.79	5,328.07	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,806.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,336.87	2,965.19
EKG/ECG	9,540.97	0.00	MRI SERVICES	0.00	9,854.80
IV THERAPY	5,285.24	1,650.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,497.20	99,550.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,362.49	10,108.40	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	556.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,983.07	14,473.41	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,159.07	570.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,781.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,390.11	3,107.80
RADIOLOGY THERAPEUTIC	13,678.77	13,215.81	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,589.35	190.66	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,806.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,511.90	10,348.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,707.04	0.00			

TOTAL ANCILLARY	320,550.31	182,834.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320,550.31	182,834.02

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,082,394.95	ADJUSTMENTS	52.94
COVERED CHARGES	921,869.59	CONTRACTUAL ALLOW	899,493.59
NON-COVERD CHARGES	160,525.36	TOTAL MEDICAID LIAB	22,376.00
		LESS: COB	0.00
		LESS: COPAYMENT	642.34
		REIMBURSEMENT	21,733.66
		TOTAL NUMBER OF CLAIMS	400

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
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,994.51	3,282.91	OTHER LAB	862.98	0.00
MED/SURG SUPPLY	16,720.75	195.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,776.21	14,271.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,155.03	67,402.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	419.00	FEE SCHEDULE LAB	91,572.49	8,174.35
EKG/ECG	23,088.49	0.00	MRI SERVICES	0.00	9,642.62
IV THERAPY	56,473.49	2,809.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,037.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,213.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	418,053.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,930.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,678.89	30,288.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	399.72	TRAUMA RESPONSE	0.00	9,800.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,155.82	12,011.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,264.90	1,828.54			
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	6,891.41	0.00			

TOTAL ANCILLARY	921,869.59	160,525.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,869.59	160,525.36

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,813.33	ADJUSTMENTS	0.00
COVERED CHARGES	3,170.61	CONTRACTUAL ALLOW	1,610.11
NON-COVERD CHARGES	642.72	TOTAL MEDICAID LIAB	1,560.50
		LESS: COB	1,554.50
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 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	589.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	920.17	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	2,250.44	0.00	SPECIAL SERVICES	0.00	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	53.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,170.61	642.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,170.61	642.72

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	467,226.16	ADJUSTMENTS	0.00
COVERED CHARGES	456,862.54	CONTRACTUAL ALLOW	434,499.46
NON-COVERD CHARGES	10,363.62	TOTAL MEDICAID LIAB	22,363.08
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	22,315.08

TOTAL NUMBER OF CLAIMS 4

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,787.79	1,038.93	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,352.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957.60	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	1,589.77	60.74
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	713.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,151.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	22,200.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,256.06	1,632.02
RADIOLOGY THERAPEUTIC	277,628.33	7,631.93	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	55,564.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,661.12	0.00			

TOTAL ANCILLARY	456,862.54	10,363.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	456,862.54	10,363.62

GEORGIA DEPARTMENT OF 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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,473,539.63	ADJUSTMENTS	9,681.27
COVERED CHARGES	3,363,967.81	CONTRACTUAL ALLOW	2,143,239.48
NON-COVERD CHARGES	109,571.82	TOTAL MEDICAID LIAB	1,220,728.33
		LESS: COB	8,445.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,212,282.94

TOTAL NUMBER OF ADMISSIONS 177

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	843	0	632,250.00	93,350.00
ROUTINE NURSERY	21	0	9,135.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	3,950.00
TOTAL ROUTINE	864	0	641,385.00	97,300.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	106	0	154,760.00	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	106	0	154,760.00	0.00
TOTAL ACCOMODATIONS	970	0	796,145.00	97,300.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	278,424.67	0.00	OTHER LAB	4,131.61	0.00
MED/SURG SUPPLY	231,002.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	410,822.94	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,676.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	139,625.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,534.64	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,926.06	0.00	MRI SERVICES	2,101.20	0.00
IV THERAPY	70,547.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,792.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,074.29	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	550,067.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,544.58	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,267.52	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,414.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,476.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,323.78	0.00	INJECTABLE DRUGS	148,881.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	268.65	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,234.82	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,117.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,941.65	11,957.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,227.87	313.97			
AUDIOLOGY	4,551.57	0.00			
CARDIOLOGY	18,529.85	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,314.88	0.00			

TOTAL ANCILLARY	2,567,822.81	12,271.82
TOTAL ACCOMODATIONS	796,145.00	97,300.00
TOTAL CHARGES	3,363,967.81	109,571.82

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,480,343.05	ADJUSTMENTS	111,717.71
COVERED CHARGES	3,331,311.61	CONTRACTUAL ALLOW	2,743,195.66
NON-COVERD CHARGES	149,031.44	TOTAL MEDICAID LIAB	588,115.95
		LESS: COB	1,236.53
		LESS: COPAYMENT	2,075.98
		REIMBURSEMENT	584,803.44
		ALL OTHER	514,700.08
		FEE SCHEDULE-LAB	67,002.09
		INJECTABLE DRUGS	3,101.27

TOTAL NUMBER OF CLAIMS 1,874

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,883.92	287.31	OTHER LAB	136,875.27	1,969.65
MED/SURG SUPPLY	174,561.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	69.33	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	195,496.14	5,930.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	507,236.05	7,938.97	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,621.87	1,699.73	FEE SCHEDULE LAB	628,724.07	31,652.95
EKG/ECG	76,145.93	5,564.13	MRI SERVICES	105,899.78	0.00
IV THERAPY	188,125.69	10,490.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	130,463.72	33,342.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,684.16	6,784.80	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,724.58	4,114.81	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	116,655.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,286.91	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	652,467.80	1,242.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,903.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,207.36	11,496.86
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	2,249.61	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,391.62	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,350.87	1,981.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,422.74	2,391.57			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,515.02	5,474.83			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,640.56	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	45,027.95	14,348.94			

TOTAL ANCILLARY	3,331,311.61	149,031.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,331,311.61	149,031.44

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,025.20	ADJUSTMENTS	0.00
COVERED CHARGES	65,283.69	CONTRACTUAL ALLOW	38,806.58
NON-COVERD CHARGES	2,741.51	TOTAL MEDICAID LIAB	26,477.11
		LESS: COB	26,459.11
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334.00	6.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	610.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,208.59	249.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,873.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,935.87	932.58
EKG/ECG	1,560.05	312.01	MRI SERVICES	8,343.60	0.00
IV THERAPY	4,081.20	148.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,470.57	951.92	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	14,508.22	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	804.20	24.89
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	115.36	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	553.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	65,283.69	2,741.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,283.69	2,741.51

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	195,021.72	ADJUSTMENTS	4,090.29
COVERED CHARGES	192,923.89	CONTRACTUAL ALLOW	180,366.50
NON-COVERD CHARGES	2,097.83	TOTAL MEDICAID LIAB	12,557.39
		LESS: COB	0.00
		LESS: COPAYMENT	414.00
		REIMBURSEMENT	12,143.39
		TOTAL NUMBER OF CLAIMS	200

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,139.76	27.14	OTHER LAB	4,519.31	0.00
MED/SURG SUPPLY	2,990.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,809.38	173.35	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,739.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,476.89	1,605.71
EKG/ECG	2,808.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,474.27	74.30	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	704.52	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	117,518.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,743.30	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	217.33			

TOTAL ANCILLARY	192,923.89	2,097.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	192,923.89	2,097.83

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,817.44	ADJUSTMENTS	0.00
COVERED CHARGES	10,668.66	CONTRACTUAL ALLOW	6,246.62
NON-COVERD CHARGES	148.78	TOTAL MEDICAID LIAB	4,422.04
		LESS: COB	4,407.04
		LESS: COPAYMENT	15.00
		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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	590.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	381.35	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	2,976.25	148.78
EKG/ECG	312.01	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	5,849.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	102.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,668.66	148.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,668.66	148.78

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,418,004.96	ADJUSTMENTS	32,631.18
COVERED CHARGES	2,238,834.96	CONTRACTUAL ALLOW	1,363,166.13
NON-COVERD CHARGES	179,170.00	TOTAL MEDICAID LIAB	875,668.83
		LESS: COB	31,757.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	843,911.13

TOTAL NUMBER OF ADMISSIONS 153

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	472	0	247,422.50	126,949.50
ROUTINE NURSERY	44	0	12,177.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	516	0	259,599.50	126,949.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	100	0	127,140.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	100	0	127,140.00	0.00
TOTAL ACCOMODATIONS	616	0	386,739.50	126,949.50

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,687.75	15,285.00	OTHER LAB	7,616.50	0.00
MED/SURG SUPPLY	174,956.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	387,232.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,084.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,580.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,603.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	35,678.50	0.00	MRI SERVICES	15,032.50	0.00
IV THERAPY	8,136.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	91,133.75	7,242.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,096.50	10,938.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	203,228.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,941.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,506.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,557.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,281.25	0.00	INJECTABLE DRUGS	52,666.50	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	2,455.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,444.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,472.25	10,354.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,678.75	160.00			
AUDIOLOGY	1,565.00	0.00			
CARDIOLOGY	30,986.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,591.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,881.00	8,240.25			

TOTAL ANCILLARY	1,852,095.46	52,220.50
TOTAL ACCOMODATIONS	386,739.50	126,949.50
TOTAL CHARGES	2,238,834.96	179,170.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,528,379.85	ADJUSTMENTS	28,915.08
COVERED CHARGES	3,060,956.81	CONTRACTUAL ALLOW	2,515,197.57
NON-COVERD CHARGES	467,423.04	TOTAL MEDICAID LIAB	545,759.24
		LESS: COB	1,216.77
		LESS: COPAYMENT	1,285.46
		REIMBURSEMENT	543,257.01
		ALL OTHER	466,601.39
		FEE SCHEDULE-LAB	69,652.19
		INJECTABLE DRUGS	7,003.43

TOTAL NUMBER OF CLAIMS 1,691

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,765.32	32,435.25	OTHER LAB	36,352.25	0.00
MED/SURG SUPPLY	82,896.45	466.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	306.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,992.25	46,269.25	OTHER THERAPEUTIC SVC	0.00	393.50
CT SCAN	602,677.50	142,140.00	SPECIAL CHARGES	281.25	0.00
PHYSICAL THERAPY	13,538.75	4.25	FEE SCHEDULE LAB	768,724.43	52,223.50
EKG/ECG	68,167.25	4,417.00	MRI SERVICES	49,024.50	7,412.50
IV THERAPY	83,062.00	18,626.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	99,004.61	52,888.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,796.00	104.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,491.50	10,580.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,803.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	580,485.75	12,831.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,339.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	79,732.00	24,531.50
RADIOLOGY THERAPEUTIC	2,213.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,161.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	290.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	924.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	142.25
OTHER IMAGING SERVICE	44,684.00	6,808.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,458.75	2,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,630.25	19,768.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,161.00	23,677.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	83,512.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,161.00	6,957.00			

TOTAL ANCILLARY	3,060,956.81	467,423.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,060,956.81	467,423.04

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 08/01/17 THROUGH 07/31/18
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
8502	2218062001096	02/06/18 - 02/06/18	03/12/18	0.00	142.25	0.00	0.00	0.00
TOTAL				0.00	142.25	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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,963.96	ADJUSTMENTS	0.00
COVERED CHARGES	7,912.46	CONTRACTUAL ALLOW	3,838.28
NON-COVERD CHARGES	3,051.50	TOTAL MEDICAID LIAB	4,074.18
		LESS: COB	4,067.81
		LESS: COPAYMENT	6.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	284.65	16.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	338.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,139.50	810.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,166.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,522.50	58.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,627.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,912.46	3,051.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,912.46	3,051.50

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,011.63	ADJUSTMENTS	2,656.38
COVERED CHARGES	438,311.95	CONTRACTUAL ALLOW	416,651.85
NON-COVERD CHARGES	33,699.68	TOTAL MEDICAID LIAB	21,660.10
		LESS: COB	23.94
		LESS: COPAYMENT	807.00
		REIMBURSEMENT	20,829.16

TOTAL NUMBER OF CLAIMS 374

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,122.50	4,164.00	OTHER LAB	741.50	0.00
MED/SURG SUPPLY	3,314.70	101.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,128.25	9,696.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	104,599.25	7,103.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,787.75	6,850.75
EKG/ECG	8,222.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,825.75	430.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292.25	1,127.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	180,237.00	236.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,726.00	1,432.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,468.25	2,556.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	743.75	0.00			

TOTAL ANCILLARY	438,311.95	33,699.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	438,311.95	33,699.68

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,150.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,117.00	CONTRACTUAL ALLOW	3,653.99
NON-COVERD CHARGES	33.25	TOTAL MEDICAID LIAB	463.01
		LESS: COB	463.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283.00	4.00	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	968.50	29.25
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	1,983.50	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	259.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	623.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,117.00	33.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,117.00	33.25

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	159,495.89	ADJUSTMENTS	5,542.23
COVERED CHARGES	157,933.39	CONTRACTUAL ALLOW	130,207.24
NON-COVERD CHARGES	1,562.50	TOTAL MEDICAID LIAB	27,726.15
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	27,663.15

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,353.00	74.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	900.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,231.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,437.25	151.25
EKG/ECG	334.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,371.75	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	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	1,293.00	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	111,091.00	0.00
RADIOLOGY THERAPEUTIC	2,790.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	819.50	1,337.25			

TOTAL ANCILLARY	157,933.39	1,562.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	157,933.39	1,562.50

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

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,135,152.52	ADJUSTMENTS	322,410.15
COVERED CHARGES	26,884,223.10	CONTRACTUAL ALLOW	21,267,169.70
NON-COVERD CHARGES	250,929.42	TOTAL MEDICAID LIAB	5,617,053.40
		LESS: COB	93,425.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,523,627.55

TOTAL NUMBER OF ADMISSIONS 580

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,562	0	2,018,104.00	88,957.00
ROUTINE NURSERY	130	0	57,460.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,692	0	2,075,564.00	88,957.00
SPECIAL CARE SERVICES				
CCU	756	0	1,861,866.00	40,224.00
ICU	368	0	1,321,488.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,124	0	3,183,354.00	40,224.00
TOTAL ACCOMODATIONS	2,816	0	5,258,918.00	129,181.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,037,655.59	27,794.50	OTHER LAB	174,932.00	0.00
MED/SURG SUPPLY	804,248.01	7,897.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,336,436.00	11,889.00	EDUCATION & TRAINING	2,720.00	0.00
RADIOLOGY-DIAGNOSTIC	665,771.00	1,107.00	OTHER THERAPEUTIC SVC	0.00	862.00
CT SCAN	1,687,136.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,123.38	392.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	261,124.00	1,024.00	MRI SERVICES	526,115.00	0.00
IV THERAPY	443,851.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,299,333.00	5,848.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	512,484.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,139,076.00	19,312.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	521,913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,059.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,297,396.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	152,703.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,007.50
LABORATORY PATHOLOGIC	156,497.50	0.00	INJECTABLE DRUGS	566.00	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	49,454.14	1,457.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	904,815.00	17,964.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,312.00	1,518.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,188.00	0.00	IMPL DEV CHARGE PATIENTS	241,081.17	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	471.00
OTHER IMAGING SERVICE	178,433.00	1,876.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	478,017.00	3,354.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	202,517.00	1,701.00			
AUDIOLOGY	23,485.00	0.00			
CARDIOLOGY	1,042,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,507.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	301,697.31	12,274.00			

TOTAL ANCILLARY	21,625,305.10	121,748.42
TOTAL ACCOMODATIONS	5,258,918.00	129,181.00
TOTAL CHARGES	26,884,223.10	250,929.42

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 07/01/17 THROUGH 06/30/18
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	2017305052264	10/22/17 - 10/24/17	11/06/17	0.00	157.00	0.00	0.00	0.00
780	2018005053608	11/05/17 - 11/09/17	01/08/18	0.00	157.00	0.00	0.00	0.00
780	2018045043821	01/18/18 - 02/06/18	02/19/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	471.00	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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	424,384.54	ADJUSTMENTS	0.00
COVERED CHARGES	422,368.54	CONTRACTUAL ALLOW	248,557.98
NON-COVERD CHARGES	2,016.00	TOTAL MEDICAID LIAB	173,810.56
		LESS: COB	173,810.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	36	0	46,512.00	2,016.00
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	36	0	46,512.00	2,016.00
SPECIAL CARE SERVICES				
CCU	6	0	15,084.00	0.00
ICU	16	0	57,456.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	72,540.00	0.00
TOTAL ACCOMODATIONS	58	0	119,052.00	2,016.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,565.25	0.00	OTHER LAB	4,148.00	0.00
MED/SURG SUPPLY	14,680.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	62,778.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,924.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,156.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	338.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,536.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,785.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,119.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,443.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,277.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,173.00	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	6,137.00	0.00			

TOTAL ANCILLARY	303,316.54	0.00
TOTAL ACCOMODATIONS	119,052.00	2,016.00
TOTAL CHARGES	422,368.54	2,016.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,287,095.02	ADJUSTMENTS	297,980.83
COVERED CHARGES	16,132,954.13	CONTRACTUAL ALLOW	13,970,932.05
NON-COVERD CHARGES	1,154,140.89	TOTAL MEDICAID LIAB	2,162,022.08
		LESS: COB	28,414.21
		LESS: COPAYMENT	3,567.00
		REIMBURSEMENT	2,130,040.87
		ALL OTHER	1,849,027.29
		FEE SCHEDULE-LAB	155,801.69
		INJECTABLE DRUGS	125,211.89

TOTAL NUMBER OF CLAIMS 4,389

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,231.75	1,650.00	OTHER LAB	302,503.00	634.00
MED/SURG SUPPLY	170,738.71	3,929.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	134.15	EDUCATION & TRAINING	0.00	75.00
RADIOLOGY-DIAGNOSTIC	984,529.00	11,842.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,897,744.00	232,503.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,302.00	29,263.05	FEE SCHEDULE LAB	2,214,181.52	127,673.81
EKG/ECG	270,732.00	4,608.00	MRI SERVICES	554,588.00	67,235.00
IV THERAPY	841,191.00	56,443.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	746,353.25	61,392.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,240.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81,103.00	78,858.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	298,205.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,250.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,873,007.00	13,772.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,475.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	600,659.75	92,338.25
RADIOLOGY THERAPEUTIC	696.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,875.00	0.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,964.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	39,727.00	11,502.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	47,257.00	72,271.00	IMPL DEV CHARGE PATIENTS	70,842.79	2,079.00
LITHOTRIPSY	0.00	35,958.00	NO CC/INVALID REV CODE	385.00	400.00
OTHER IMAGING SERVICE	505,944.00	62,243.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,748.00	1,765.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	277,021.00	47,970.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	206,983.00	64,152.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,110.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	334,331.36	55,485.00			

TOTAL ANCILLARY	16,132,954.13	1,154,140.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,132,954.13	1,154,140.89

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 07/01/17 THROUGH 06/30/18
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	2018011061688	12/11/17 - 12/11/17	01/15/18	77.00	0.00	0.00	0.00	20.52
780	2018011061688	12/11/17 - 12/11/17	01/15/18	0.00	80.00	0.00	0.00	0.00
780	2018071018043	02/24/18 - 02/24/18	03/19/18	77.00	0.00	0.00	0.00	20.52
780	2018071018043	02/24/18 - 02/24/18	03/19/18	0.00	80.00	0.00	0.00	0.00
780	2018100073119	03/21/18 - 03/21/18	04/16/18	77.00	0.00	0.00	0.00	20.52
780	2018100073119	03/21/18 - 03/21/18	04/16/18	0.00	80.00	0.00	0.00	0.00
780	2018114064488	04/07/18 - 04/07/18	04/30/18	77.00	0.00	0.00	0.00	20.52
780	2018114064488	04/07/18 - 04/07/18	04/30/18	0.00	80.00	0.00	0.00	0.00
780	2018120012700	04/07/18 - 04/07/18	05/07/18	77.00	0.00	0.00	0.00	20.52
780	2018120012700	04/07/18 - 04/07/18	05/07/18	0.00	80.00	0.00	0.00	0.00
TOTAL				385.00	400.00	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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	227,394.33	ADJUSTMENTS	0.00
COVERED CHARGES	185,589.69	CONTRACTUAL ALLOW	94,698.62
NON-COVERD CHARGES	41,804.64	TOTAL MEDICAID LIAB	90,891.07
		LESS: COB	90,882.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,147.00	0.00	OTHER LAB	3,980.00	0.00
MED/SURG SUPPLY	1,293.82	101.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,860.00	4,211.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,826.00	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,495.53	2,127.64
EKG/ECG	5,120.00	512.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,690.00	1,110.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,630.00	9,100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,368.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,031.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,803.00	5,129.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,564.50	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	111.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,765.00	3,946.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	9,414.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,304.00	0.00			

TOTAL ANCILLARY	185,589.69	41,804.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,589.69	41,804.64

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	750,425.50	ADJUSTMENTS	270.70
COVERED CHARGES	723,565.50	CONTRACTUAL ALLOW	705,816.97
NON-COVERD CHARGES	26,860.00	TOTAL MEDICAID LIAB	17,748.53
		LESS: COB	742.77
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	16,507.76
		TOTAL NUMBER OF CLAIMS	304

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,402.25	0.00	OTHER LAB	9,752.00	0.00
MED/SURG SUPPLY	988.00	206.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,258.00	682.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,519.00	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	130,892.00	6,288.00
EKG/ECG	8,192.00	0.00	MRI SERVICES	6,133.00	0.00
IV THERAPY	33,069.00	1,874.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,379.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	346,458.00	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	233.25	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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,829.00	8,698.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,461.00	2,958.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	723,565.50	26,860.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	723,565.50	26,860.00

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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,106.25	ADJUSTMENTS	0.00
COVERED CHARGES	11,197.25	CONTRACTUAL ALLOW	6,228.53
NON-COVERD CHARGES	2,909.00	TOTAL MEDICAID LIAB	4,968.72
		LESS: COB	4,961.72
		LESS: COPAYMENT	7.00
		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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	2,321.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,015.00	2,909.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,197.25	2,909.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,197.25	2,909.00

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,089,579.31	ADJUSTMENTS	49,215.12
COVERED CHARGES	1,071,191.81	CONTRACTUAL ALLOW	939,559.49
NON-COVERD CHARGES	18,387.50	TOTAL MEDICAID LIAB	131,632.32
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	131,407.32
		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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,842.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,769.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,678.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,445.00	0.00
EKG/ECG	1,536.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,311.00	2,404.00	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	65,280.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,878.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,346.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	793,570.00	2,425.50
RADIOLOGY THERAPEUTIC	696.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,027.00	0.00
LITHOTRIPSY	35,958.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,493.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,700.00	8,643.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,630.00	4,915.00			

TOTAL ANCILLARY	1,071,191.81	18,387.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,071,191.81	18,387.50

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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,657.43	ADJUSTMENTS	0.00
COVERED CHARGES	72,382.91	CONTRACTUAL ALLOW	45,096.18
NON-COVERD CHARGES	14,274.52	TOTAL MEDICAID LIAB	27,286.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,286.73

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	19	0	10,638.00	7,412.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	10,638.00	7,412.00
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	10,638.00	7,412.00

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,405.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	955.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,594.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	809.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,318.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	130.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,986.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	10,972.30	0.00	SPECIAL SERVICES	0.00	353.72
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,573.44	6,508.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	61,744.91	6,862.52
TOTAL ACCOMODATIONS	10,638.00	7,412.00
TOTAL CHARGES	72,382.91	14,274.52

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	852,967.45	ADJUSTMENTS	37,036.52
COVERED CHARGES	702,694.83	CONTRACTUAL ALLOW	497,968.86
NON-COVERD CHARGES	150,272.62	TOTAL MEDICAID LIAB	204,725.97
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	204,656.97
		ALL OTHER	192,278.60
		FEE SCHEDULE-LAB	12,273.89
		INJECTABLE DRUGS	104.48

TOTAL NUMBER OF CLAIMS 500

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,385.72	9,710.90	OTHER LAB	23,633.90	0.00
MED/SURG SUPPLY	7,423.84	430.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,153.79	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,952.76	18,351.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,459.10	76,260.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	535.62	FEE SCHEDULE LAB	280,917.79	20,861.32
EKG/ECG	2,794.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	984.00	PROFESSIONAL FEES	0.00	552.00
OPERATING ROOM	1,093.84	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,283.74	513.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	281,532.82	14,007.48	SPECIAL SERVICES	0.00	622.81
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238.00	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	2,328.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,983.20	1,988.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,667.30	0.00			

TOTAL ANCILLARY	702,694.83	150,272.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	702,694.83	150,272.62

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	423.54	ADJUSTMENTS	0.00
COVERED CHARGES	5.00	CONTRACTUAL ALLOW	2.80
NON-COVERD CHARGES	418.54	TOTAL MEDICAID LIAB	2.20
		LESS: COB	0.00
		LESS: COPAYMENT	2.20
		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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	14.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	404.54	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5.00	418.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5.00	418.54

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	182,144.18	ADJUSTMENTS	1,101.00
COVERED CHARGES	153,966.77	CONTRACTUAL ALLOW	148,846.77
NON-COVERD CHARGES	28,177.41	TOTAL MEDICAID LIAB	5,120.00
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	4,949.00
		TOTAL NUMBER OF CLAIMS	88

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,151.00	3,281.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,720.95	70.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	74.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,045.40	1,649.62	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,530.60	18,734.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,351.96	3,244.34
EKG/ECG	523.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	368.00	PROFESSIONAL FEES	0.00	524.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	97,611.66	0.00	SPECIAL SERVICES	0.00	109.17
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.00	122.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	153,966.77	28,177.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	153,966.77	28,177.41

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,488.82	ADJUSTMENTS	0.00
COVERED CHARGES	1,484.82	CONTRACTUAL ALLOW	383.84
NON-COVERD CHARGES	4.00	TOTAL MEDICAID LIAB	1,100.98
		LESS: COB	1,100.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	4.00	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	1,484.82	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,484.82	4.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,484.82	4.00

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,117.64	ADJUSTMENTS	4,862.89
COVERED CHARGES	15,462.30	CONTRACTUAL ALLOW	10,599.41
NON-COVERD CHARGES	3,655.34	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,862.89

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	762.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	895.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	404.54	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	3,116.88	2,486.00
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	194.86	0.00	FREE STANDING CLINIC	0.00	0.00
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	407.34
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,680.08	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.80	0.00			

TOTAL ANCILLARY	15,462.30	3,655.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,462.30	3,655.34

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	315,487.61	ADJUSTMENTS	24,941.54
COVERED CHARGES	253,114.38	CONTRACTUAL ALLOW	168,231.05
NON-COVERD CHARGES	62,373.23	TOTAL MEDICAID LIAB	84,883.33
		LESS: COB	5,252.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	79,630.38

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	41	0	45,469.00	57,851.00
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	45,469.00	57,851.00
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	41	0	45,469.00	57,851.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,120.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,857.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,773.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,080.53	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,908.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	835.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,353.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,737.00	0.00	PROFESSIONAL FEES	0.00	597.68
OPERATING ROOM	13,864.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,589.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,863.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,502.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,297.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	719.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	896.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,924.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,245.00	0.00			

TOTAL ANCILLARY	207,645.38	4,522.23
TOTAL ACCOMODATIONS	45,469.00	57,851.00
TOTAL CHARGES	253,114.38	62,373.23

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,820.40	ADJUSTMENTS	0.00
COVERED CHARGES	36,710.40	CONTRACTUAL ALLOW	9,110.78
NON-COVERD CHARGES	14,110.00	TOTAL MEDICAID LIAB	27,599.62
		LESS: COB	27,599.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10	0	11,090.00	14,110.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	11,090.00	14,110.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	10	0	11,090.00	14,110.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,298.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	194.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,581.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	438.00	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	3,658.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	450.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,620.40	0.00
TOTAL ACCOMODATIONS	11,090.00	14,110.00
TOTAL CHARGES	36,710.40	14,110.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,661,805.49	ADJUSTMENTS	171,413.02
COVERED CHARGES	3,430,657.88	CONTRACTUAL ALLOW	2,798,518.61
NON-COVERD CHARGES	231,147.61	TOTAL MEDICAID LIAB	632,139.27
		LESS: COB	856.75
		LESS: COPAYMENT	1,225.70
		REIMBURSEMENT	630,056.82
		ALL OTHER	580,014.05
		FEE SCHEDULE-LAB	40,299.12
		INJECTABLE DRUGS	9,743.65

TOTAL NUMBER OF CLAIMS 1,396

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,403.49	5,184.45	OTHER LAB	31,905.56	0.00
MED/SURG SUPPLY	41,147.90	1,196.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	219,355.78	29,837.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	498,482.11	64,153.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,697.57	901.68	FEE SCHEDULE LAB	445,433.44	16,084.14
EKG/ECG	30,937.98	270.71	MRI SERVICES	119,150.64	2,836.00
IV THERAPY	116,212.46	1,642.06	PROFESSIONAL FEES	0.00	66.34
OPERATING ROOM	131,474.91	5,434.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,487.60	8,318.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,278.17	972.00	AMBULANCE	0.00	0.00
GI SERVICES	24,412.85	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	658,732.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,622.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	681,906.31	48,471.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	514.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	163.54	3,076.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,920.00	22,250.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	84,747.01	3,807.03			
BLOOD	971.95	971.95			
BLOOD STORAGE & PRO.	11,677.95	0.00			
ONCOLOGY	69,870.76	0.00			
NUCLEAR MEDICINE	5,769.23	300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,666.71	2,575.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,228.38	12,285.00			

TOTAL ANCILLARY	3,430,657.88	231,147.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,430,657.88	231,147.61

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,038.75	ADJUSTMENTS	0.00
COVERED CHARGES	45,727.44	CONTRACTUAL ALLOW	16,572.88
NON-COVERD CHARGES	17,311.31	TOTAL MEDICAID LIAB	29,154.56
		LESS: COB	29,147.04
		LESS: COPAYMENT	7.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,430.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,129.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,872.05	1,989.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,544.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,088.11	412.10
EKG/ECG	475.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,623.38	46.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,300.78	3,274.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,908.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,234.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	683.34	1,046.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	6,201.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,085.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	165.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	45,727.44	17,311.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,727.44	17,311.31

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,759.68	ADJUSTMENTS	429.00
COVERED CHARGES	194,444.35	CONTRACTUAL ALLOW	185,844.35
NON-COVERD CHARGES	4,315.33	TOTAL MEDICAID LIAB	8,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	8,324.00
		TOTAL NUMBER OF CLAIMS	172

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,850.60	165.85	OTHER LAB	972.00	0.00
MED/SURG SUPPLY	490.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,293.99	1,812.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,586.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,382.13	1,154.25
EKG/ECG	812.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,581.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,000.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,565.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,436.38	510.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	474.00	672.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	194,444.35	4,315.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,444.35	4,315.33

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,752.55	ADJUSTMENTS	0.00
COVERED CHARGES	9,184.55	CONTRACTUAL ALLOW	3,141.45
NON-COVERD CHARGES	4,568.00	TOTAL MEDICAID LIAB	6,043.10
		LESS: COB	6,043.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	422.70	0.00	OTHER LAB	972.00	0.00
MED/SURG SUPPLY	56.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,351.07	64.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,224.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,176.00	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	264.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,184.55	4,568.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,184.55	4,568.00

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

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	168,790.08	ADJUSTMENTS	6,846.30
COVERED CHARGES	168,534.08	CONTRACTUAL ALLOW	141,136.88
NON-COVERD CHARGES	256.00	TOTAL MEDICAID LIAB	27,397.20
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	27,388.20

TOTAL NUMBER OF CLAIMS 4

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

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,844.27	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	317.41	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	153,594.50	256.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	10,777.90	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	168,534.08	256.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,534.08	256.00

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

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	258,246.53	ADJUSTMENTS	9,505.38
COVERED CHARGES	252,357.53	CONTRACTUAL ALLOW	104,029.47
NON-COVERD CHARGES	5,889.00	TOTAL MEDICAID LIAB	148,328.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	148,328.06

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	50,464.00	4,011.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	83	0	50,464.00	4,011.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	83	0	50,464.00	4,011.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,264.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,115.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,442.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,438.28	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,110.96	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	491.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,415.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,680.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,798.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,506.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,980.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	200.00	0.00	INJECTABLE DRUGS	44.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	284.48	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	1,878.00
OTHER IMAGING SERVICE	1,457.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	415.11	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,512.93	0.00			
AMBULATORY SURGERY	0.00	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	0.00			

TOTAL ANCILLARY	201,893.53	1,878.00
TOTAL ACCOMODATIONS	50,464.00	4,011.00
TOTAL CHARGES	252,357.53	5,889.00

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 07/01/17 THROUGH 06/30/18
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	2018123071260	04/05/18 - 04/13/18	05/07/18	0.00	1,878.00	0.00	0.00	0.00
TOTAL				0.00	1,878.00	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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,098,376.73	ADJUSTMENTS	50,096.45
COVERED CHARGES	965,638.03	CONTRACTUAL ALLOW	728,699.88
NON-COVERD CHARGES	132,738.70	TOTAL MEDICAID LIAB	236,938.15
		LESS: COB	0.00
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	236,008.15
		ALL OTHER	205,957.53
		FEE SCHEDULE-LAB	28,840.21
		INJECTABLE DRUGS	1,210.41

TOTAL NUMBER OF CLAIMS 805

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,943.35	31,032.35	OTHER LAB	10,892.75	0.00
MED/SURG SUPPLY	15,240.69	3,439.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,884.13	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,337.86	8,592.41	OTHER THERAPEUTIC SVC	0.00	62.00
CT SCAN	116,314.84	23,376.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,781.75	10,378.04	FEE SCHEDULE LAB	206,845.82	6,644.98
EKG/ECG	14,268.00	1,640.00	MRI SERVICES	42,509.49	0.00
IV THERAPY	44,675.24	2,876.57	PROFESSIONAL FEES	0.00	2,335.86
OPERATING ROOM	97,716.70	17,900.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,689.04	2,983.94	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,899.00	796.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	217,779.62	4,266.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,085.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,679.55	2,884.20
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	4,103.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,719.27
OTHER IMAGING SERVICE	24,759.06	2,432.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,160.62	645.82			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,564.65	1,512.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,495.00	1,231.92			

TOTAL ANCILLARY	965,638.03	132,738.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	965,638.03	132,738.70

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 07/01/17 THROUGH 06/30/18
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	2017226019200	07/21/17 - 07/21/17	08/21/17	0.00	1,719.27	0.00	0.00	0.00
TOTAL				0.00	1,719.27	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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,517.23	ADJUSTMENTS	0.00
COVERED CHARGES	3,777.77	CONTRACTUAL ALLOW	3,413.81
NON-COVERD CHARGES	1,739.46	TOTAL MEDICAID LIAB	363.96
		LESS: COB	363.69
		LESS: COPAYMENT	0.27
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180.00	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	2,115.31	353.68
EKG/ECG	0.00	328.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	1,057.78	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,395.46	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	68.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,777.77	1,739.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,777.77	1,739.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	131,498.00	ADJUSTMENTS	856.04
COVERED CHARGES	115,916.55	CONTRACTUAL ALLOW	109,427.51
NON-COVERD CHARGES	15,581.45	TOTAL MEDICAID LIAB	6,489.04
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	6,204.04
		TOTAL NUMBER OF CLAIMS	116

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222.10	1,202.00	OTHER LAB	658.43	0.00
MED/SURG SUPPLY	105.50	151.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,057.76	1,108.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,199.05	11,908.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,091.39	795.68
EKG/ECG	1,312.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,196.38	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	101.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,148.93	319.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,093.00	96.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,430.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	300.00	0.00			

TOTAL ANCILLARY	115,916.55	15,581.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,916.55	15,581.45

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,238,644.27	ADJUSTMENTS	14,045.40
COVERED CHARGES	4,186,564.27	CONTRACTUAL ALLOW	3,071,976.71
NON-COVERD CHARGES	1,052,080.00	TOTAL MEDICAID LIAB	1,114,587.56
		LESS: COB	25,881.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,088,705.66

TOTAL NUMBER OF ADMISSIONS 188

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,327	0	659,367.00	1,033,369.00
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	1,327	0	659,367.00	1,033,369.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	152	0	167,504.00	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	152	0	167,504.00	0.00
TOTAL ACCOMODATIONS	1,479	0	826,871.00	1,033,369.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,241,217.75	0.00	OTHER LAB	17,983.00	0.00
MED/SURG SUPPLY	82,253.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	690,311.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	94,364.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	289,017.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,576.62	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	45,497.00	0.00	MRI SERVICES	24,388.00	0.00
IV THERAPY	104,650.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,226.00	8,961.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332,756.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	288,791.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,365.00	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	18,186.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,755.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	606.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,359.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,133.00	9,674.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,047.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,855.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,356.00	0.00			

TOTAL ANCILLARY	3,359,693.27	18,711.00
TOTAL ACCOMODATIONS	826,871.00	1,033,369.00
TOTAL CHARGES	4,186,564.27	1,052,080.00

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,153.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,711.00	CONTRACTUAL ALLOW	4,154.64
NON-COVERD CHARGES	15,442.00	TOTAL MEDICAID LIAB	10,556.36
		LESS: COB	10,556.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	6,958.00	15,442.00
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	6,958.00	15,442.00
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	6,958.00	15,442.00

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,396.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,278.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	778.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,753.00	0.00
TOTAL ACCOMODATIONS	6,958.00	15,442.00
TOTAL CHARGES	14,711.00	15,442.00

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,613,826.86	ADJUSTMENTS	39,652.44
COVERED CHARGES	4,384,578.16	CONTRACTUAL ALLOW	3,783,022.02
NON-COVERD CHARGES	229,248.70	TOTAL MEDICAID LIAB	601,556.14
		LESS: COB	1,766.71
		LESS: COPAYMENT	996.00
		REIMBURSEMENT	598,793.43
		ALL OTHER	519,446.14
		FEE SCHEDULE-LAB	79,320.10
		INJECTABLE DRUGS	27.19

TOTAL NUMBER OF CLAIMS 1,825

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380,865.91	91.00	OTHER LAB	17,198.00	0.00
MED/SURG SUPPLY	123,180.00	1,879.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	229.35	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	227,696.00	14,187.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	604,727.00	32,089.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,045,777.25	57,237.35
EKG/ECG	61,650.00	0.00	MRI SERVICES	45,571.00	0.00
IV THERAPY	281,767.00	15,997.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,954.00	4,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,048.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,702.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,691.00	27,938.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128.00	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	1,054.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,124.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	3,634.00	0.00
OTHER IMAGING SERVICE	125,841.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,579.00	4,200.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	32,117.00	31,592.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,496.00	3,690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,484.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200,832.00	31,732.00			

TOTAL ANCILLARY	4,384,578.16	229,248.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,384,578.16	229,248.70

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 07/01/17 THROUGH 06/30/18
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	2017243073996	08/22/17 - 08/22/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042221	09/08/17 - 09/08/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042224	09/01/17 - 09/01/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042225	09/01/17 - 09/01/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017275017353	09/15/17 - 09/15/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067922	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067925	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067945	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017297040497	10/06/17 - 10/06/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017319065948	10/17/17 - 10/17/17	11/20/17	79.00	0.00	0.00	0.00	20.52
780	2017341067133	11/14/17 - 11/14/17	12/11/17	79.00	0.00	0.00	0.00	20.52
780	2017354069406	10/24/17 - 10/24/17	12/25/17	79.00	0.00	0.00	0.00	20.52
780	2017354069528	11/02/17 - 11/02/17	12/25/17	79.00	0.00	0.00	0.00	20.52
780	2018011070716	12/12/17 - 12/12/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018011070805	12/07/17 - 12/07/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018011070808	12/07/17 - 12/07/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018043024284	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024286	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024287	01/26/18 - 01/26/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024302	01/18/18 - 01/18/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024303	02/01/18 - 02/01/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018044072559	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018053066660	02/08/18 - 02/08/18	02/26/18	79.00	0.00	0.00	0.00	20.52
780	2018053066808	02/08/18 - 02/08/18	02/26/18	79.00	0.00	0.00	0.00	20.52
780	2018058041690	02/06/18 - 02/06/18	03/05/18	79.00	0.00	0.00	0.00	20.52
780	2018079070276	03/05/18 - 03/05/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070280	03/06/18 - 03/06/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070291	03/05/18 - 03/05/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070294	03/06/18 - 03/06/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018080058662	03/14/18 - 03/14/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018081071333	03/15/18 - 03/15/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018127025067	04/11/18 - 04/11/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025070	04/11/18 - 04/11/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025098	04/05/18 - 04/05/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025106	04/12/18 - 04/12/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025107	04/05/18 - 04/05/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018141028100	05/11/18 - 05/11/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018141028103	05/08/18 - 05/08/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018144073319	04/05/18 - 04/05/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018151035356	05/03/18 - 05/03/18	06/04/18	79.00	0.00	0.00	0.00	20.52
780	2018158071304	05/31/18 - 05/31/18	06/11/18	79.00	0.00	0.00	0.00	20.52
780	2018158071672	05/31/18 - 05/31/18	06/11/18	79.00	0.00	0.00	0.00	20.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	2018169015133	06/05/18 - 06/05/18	06/25/18	79.00	0.00	0.00	0.00	20.52
780	2018178028890	06/11/18 - 06/11/18	07/02/18	79.00	0.00	0.00	0.00	20.52
780	2018178028891	06/14/18 - 06/14/18	07/02/18	79.00	0.00	0.00	0.00	20.52
780	2018178028898	06/14/18 - 06/14/18	07/02/18	79.00	0.00	0.00	0.00	20.52
TOTAL				3,634.00	0.00	0.00	0.00	943.92

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,655.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,073.00	CONTRACTUAL ALLOW	23,068.65
NON-COVERD CHARGES	7,582.00	TOTAL MEDICAID LIAB	13,004.35
		LESS: COB	12,998.35
		LESS: COPAYMENT	6.00
		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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,467.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,843.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	640.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,686.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,971.00	202.00
EKG/ECG	598.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,217.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,931.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86.00	485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,073.00	7,582.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,073.00	7,582.00

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	700,600.40	ADJUSTMENTS	108.88
COVERED CHARGES	678,650.40	CONTRACTUAL ALLOW	659,966.44
NON-COVERD CHARGES	21,950.00	TOTAL MEDICAID LIAB	18,683.96
		LESS: COB	0.00
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	18,095.96
		TOTAL NUMBER OF CLAIMS	334

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,390.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,475.00	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,209.00	2,607.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,310.00	6,688.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	121,654.10	7,914.00
EKG/ECG	5,328.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45,845.00	1,063.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,161.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304,661.00	2,015.00	SPECIAL SERVICES	0.00	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	60.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,605.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,332.00	1,400.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,680.00	0.00			

TOTAL ANCILLARY	678,650.40	21,950.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	678,650.40	21,950.00

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,644.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,604.00	CONTRACTUAL ALLOW	4,863.34
NON-COVERD CHARGES	3,040.00	TOTAL MEDICAID LIAB	4,740.66
		LESS: COB	4,731.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	654.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	351.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,686.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,299.00	354.00
EKG/ECG	299.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	5,935.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,604.00	3,040.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,604.00	3,040.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	161,544,676.09	ADJUSTMENTS	11,335,064.09
COVERED CHARGES	150,167,453.30	CONTRACTUAL ALLOW	105,566,566.06
NON-COVERD CHARGES	11,377,222.79	TOTAL MEDICAID LIAB	44,600,887.24
		LESS: COB	414,275.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	44,186,612.15

TOTAL NUMBER OF ADMISSIONS 1,783

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,884	0	15,315,254.00	1,984,928.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,884	0	15,315,254.00	1,984,928.00
SPECIAL CARE SERVICES				
CCU	455	0	2,696,960.00	115,292.00
ICU	5,673	0	25,944,163.00	1,201,311.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,128	0	28,641,123.00	1,316,603.00
TOTAL ACCOMODATIONS	17,012	0	43,956,377.00	3,301,531.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,734,075.86	351,767.92	OTHER LAB	667,605.00	26,380.00
MED/SURG SUPPLY	5,611,756.40	716,482.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,056,815.41	1,083,451.00	EDUCATION & TRAINING	59.00	0.00
RADIOLOGY-DIAGNOSTIC	2,011,555.36	98,070.88	OTHER THERAPEUTIC SVC	0.00	7,923.00
CT SCAN	4,242,399.00	145,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	908,170.50	31,094.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	405,506.00	17,248.00	MRI SERVICES	2,007,327.00	30,041.00
IV THERAPY	98.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,594,557.00	421,935.00	DURABLE MED. EQUIP.	0.00	8,905.68
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,184,502.00	251,138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,681,439.00	65,219.00	AMBULANCE	0.00	0.00
GI SERVICES	537,651.00	20,616.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,792,784.00	11,133.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	905,568.00	13,844.00	DRUG-SPECIFIC/HOME IV	0.00	306,605.18
LABORATORY PATHOLOGIC	882,488.00	31,968.00	INJECTABLE DRUGS	20,909,708.26	2,063,065.61
RADIOLOGY THERAPEUTIC	244,947.00	1,659.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	732,741.97	29,796.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	340,936.53	6,278.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,180,572.00	113,240.00	PATIENT CONVENIENCE	0.00	996.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,984.00	503.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	288.00	0.00	IMPL DEV CHARGE PATIENTS	4,766,050.51	181,987.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	414,234.00
OTHER IMAGING SERVICE	294,470.00	222,924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,949,825.00	1,000,823.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,763.00	105,909.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,555,313.00	156,412.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,961,027.00	79,699.00			
ORGAN ACQUISITION	1,807,562.50	48,982.00			
TREATMENT/OBSERV. RM	114,531.00	10,357.00			

TOTAL ANCILLARY	106,211,076.30	8,075,691.79
TOTAL ACCOMODATIONS	43,956,377.00	3,301,531.00
TOTAL CHARGES	150,167,453.30	11,377,222.79

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 09/01/17 THROUGH 08/31/18
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	2017258064347	09/08/17 - 09/10/17	09/25/17	0.00	8,958.00	0.00	0.00	0.00
615	2017283093309	09/26/17 - 09/28/17	10/16/17	0.00	4,479.00	0.00	0.00	0.00
615	2017296023888	09/12/17 - 09/29/17	10/30/17	0.00	8,958.00	0.00	0.00	0.00
615	5217321000384	09/12/17 - 10/12/17	11/27/17	0.00	2,698.00	0.00	0.00	0.00
615	2017326086109	11/16/17 - 11/17/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2217354013386	10/06/17 - 10/11/17	12/25/17	0.00	8,958.00	0.00	0.00	0.00
614	2017361054051	11/30/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
614	2318022000292	09/20/17 - 09/28/17	02/12/18	0.00	8,958.00	0.00	1,303.79	0.00
614	2318022000307	10/01/17 - 10/05/17	02/12/18	0.00	4,479.00	0.00	2,358.54	0.00
615	5218037000002	10/17/17 - 01/01/18	02/12/18	0.00	11,656.00	0.00	0.00	0.00
615	2018045067228	12/17/17 - 12/22/17	02/19/18	0.00	8,958.00	0.00	0.00	0.00
615	2018055067633	02/11/18 - 02/15/18	03/05/18	0.00	8,958.00	0.00	0.00	0.00
615	5218075000386	01/22/18 - 01/30/18	03/26/18	0.00	2,698.00	0.00	0.00	0.00
615	2018081097344	03/11/18 - 03/17/18	03/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018085027475	02/15/18 - 02/23/18	04/02/18	0.00	4,479.00	0.00	0.00	0.00
614	2318093000267	12/25/17 - 01/09/18	04/16/18	0.00	4,479.00	0.00	4,456.93	0.00
615	2018093092107	02/23/18 - 03/26/18	04/09/18	0.00	8,958.00	0.00	0.00	0.00
615	2018103062547	04/03/18 - 04/06/18	04/16/18	0.00	8,958.00	0.00	0.00	0.00
615	2018108085086	11/14/17 - 11/27/17	04/23/18	0.00	8,958.00	0.00	0.00	0.00
614	2018128072711	04/10/18 - 04/19/18	05/14/18	0.00	4,479.00	0.00	0.00	0.00
614	2218129005282	10/28/17 - 11/09/17	05/14/18	0.00	4,479.00	0.00	0.00	0.00
614	2018136069412	11/23/17 - 12/07/17	05/21/18	0.00	4,479.00	0.00	0.00	0.00
615	2018137093798	05/08/18 - 05/12/18	05/21/18	0.00	2,698.00	0.00	0.00	0.00
615	2018144093407	05/13/18 - 05/17/18	05/28/18	0.00	2,698.00	0.00	0.00	0.00
615	2218158004739	04/21/18 - 04/23/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018162022651	06/01/18 - 06/04/18	06/18/18	0.00	8,958.00	0.00	0.00	0.00
615	2218170003816	12/13/17 - 02/01/18	06/25/18	0.00	2,698.00	0.00	0.00	0.00
614	2018172093125	04/23/18 - 05/04/18	06/25/18	0.00	4,636.00	0.00	0.00	0.00
615	2018179078482	05/25/18 - 06/21/18	07/02/18	0.00	2,698.00	0.00	0.00	0.00
614	2018186097450	04/03/18 - 04/20/18	07/09/18	0.00	8,958.00	0.00	0.00	0.00
615	2018191069044	06/07/18 - 07/04/18	07/16/18	0.00	7,177.00	0.00	0.00	0.00
614	5218193000343	10/02/17 - 11/10/17	07/16/18	0.00	2,698.00	0.00	0.00	0.00
615	2218205009924	06/01/18 - 06/06/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
614	2218211003639	03/20/18 - 03/30/18	08/06/18	0.00	4,636.00	0.00	0.00	0.00
615	2018227085376	07/29/18 - 07/31/18	08/20/18	0.00	8,958.00	0.00	0.00	0.00
615	2218229012066	01/02/18 - 03/02/18	08/20/18	0.00	4,479.00	0.00	0.00	0.00
615	2218232004298	07/23/18 - 07/24/18	08/27/18	0.00	4,479.00	0.00	0.00	0.00
615	2018234066138	08/11/18 - 08/17/18	08/27/18	0.00	2,698.00	0.00	0.00	0.00
614	2318239000018	03/26/18 - 04/10/18	09/10/18	0.00	4,479.00	0.00	7,912.31	0.00
615	2018239031483	08/10/18 - 08/20/18	09/03/18	0.00	8,958.00	0.00	0.00	0.00
614	2018241066191	06/22/18 - 07/24/18	09/03/18	0.00	4,479.00	0.00	0.00	0.00
615	5218241000164	05/01/18 - 06/12/18	09/03/18	0.00	4,479.00	0.00	0.00	0.00

EMORY UNIV HOSPPT FINANCIALSERV
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ATLANTA,GA 30322-1059

PROVIDER NUMBER
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SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2318278000093	08/16/18 - 08/21/18	10/22/18	0.00	4,479.00	0.00	2,432.72	0.00
618	2318278000093	08/16/18 - 08/21/18	10/22/18	0.00	3,221.00	0.00	2,432.72	0.00
614	2318285000300	08/17/18 - 08/20/18	10/29/18	0.00	8,958.00	0.00	1,504.08	0.00
615	2318288000270	06/02/18 - 06/12/18	11/05/18	0.00	8,958.00	0.00	0.00	0.00
615	2318291000361	05/03/18 - 05/05/18	11/19/18	0.00	8,958.00	0.00	0.00	0.00
614	5218296000136	09/04/17 - 11/18/17	10/29/18	0.00	7,177.00	0.00	0.00	0.00
614	2318310000371	04/29/18 - 05/02/18	11/19/18	0.00	8,958.00	0.00	1,590.86	0.00
614	5218312000161	06/27/18 - 07/18/18	11/12/18	0.00	8,958.00	0.00	0.00	0.00
615	2019009054581	07/23/18 - 07/31/18	01/14/19	0.00	8,958.00	0.00	0.00	0.00
614	2019031098704	09/30/17 - 10/15/17	02/04/19	0.00	4,479.00	0.00	0.00	0.00
615	2219050009557	06/23/18 - 07/06/18	02/25/19	0.00	7,177.00	0.00	0.00	0.00
614	2219063004210	08/18/18 - 09/18/18	03/11/19	0.00	8,958.00	0.00	0.00	0.00
614	5219063000162	02/03/18 - 04/27/18	03/11/19	0.00	8,958.00	0.00	40,394.95	0.00
614	5219067000187	06/07/18 - 06/16/18	03/18/19	0.00	8,958.00	0.00	0.00	0.00
614	2319079000060	08/18/18 - 09/17/18	04/01/19	0.00	2,428.00	0.00	1,547.49	0.00
614	2319081000282	07/09/18 - 07/19/18	04/15/19	0.00	3,221.00	0.00	0.00	0.00
614	5219095000148	09/15/17 - 10/05/17	04/15/19	0.00	4,479.00	0.00	0.00	0.00
615	5219095000148	09/15/17 - 10/05/17	04/15/19	0.00	8,958.00	0.00	0.00	0.00
614	5219107000177	01/05/18 - 02/07/18	04/22/19	0.00	8,958.00	0.00	0.00	0.00
614	2019121084943	08/06/18 - 08/15/18	05/06/19	0.00	2,698.00	0.00	0.00	0.00
615	2219134009886	04/08/18 - 05/04/18	05/20/19	0.00	4,479.00	0.00	0.00	0.00
615	2019151065298	07/29/18 - 08/10/18	06/10/19	0.00	4,479.00	0.00	0.00	0.00
614	5219155000146	03/25/18 - 06/22/18	06/10/19	0.00	4,479.00	0.00	20,242.10	0.00
615	2019178079194	07/30/18 - 07/31/18	07/01/19	0.00	8,958.00	0.00	0.00	0.00
614	2019184101636	05/04/18 - 05/21/18	07/08/19	0.00	8,958.00	0.00	0.00	0.00
615	5219184000170	03/24/18 - 09/14/18	07/08/19	0.00	2,698.00	0.00	122,966.70	0.00
TOTAL				0.00	414,234.00	0.00	209,143.19	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,106,560.88	ADJUSTMENTS	0.00
COVERED CHARGES	1,085,545.88	CONTRACTUAL ALLOW	440,544.37
NON-COVERD CHARGES	21,015.00	TOTAL MEDICAID LIAB	645,001.51
		LESS: COB	645,001.51
		LESS: COPAYMENT	0.00
		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	103	0	151,494.00	10,216.00
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	103	0	151,494.00	10,216.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	43,001.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	43,001.00	0.00
TOTAL ACCOMODATIONS	110	0	194,495.00	10,216.00

EMORY UNIV HOSPPT FINANCIALSERV
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SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,552.72	0.00	OTHER LAB	1,959.00	0.00
MED/SURG SUPPLY	35,436.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	115,878.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,919.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,647.00	714.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,939.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,156.00	0.00	MRI SERVICES	14,354.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	182,775.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,664.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,793.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,185.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,672.00	0.00	INJECTABLE DRUGS	67,982.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	688.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,079.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,652.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	69,910.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,582.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	837.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,965.00	10,085.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,738.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,740.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,355.00	0.00			

TOTAL ANCILLARY	891,050.88	10,799.00
TOTAL ACCOMODATIONS	194,495.00	10,216.00
TOTAL CHARGES	1,085,545.88	21,015.00

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

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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,149,151.56	ADJUSTMENTS	709,653.52
COVERED CHARGES	20,370,777.13	CONTRACTUAL ALLOW	16,802,103.23
NON-COVERD CHARGES	9,778,374.43	TOTAL MEDICAID LIAB	3,568,673.90
		LESS: COB	12,529.78
		LESS: COPAYMENT	11,022.99
		REIMBURSEMENT	3,545,121.13
		ALL OTHER	2,733,328.18
		FEE SCHEDULE-LAB	759,205.60
		INJECTABLE DRUGS	52,587.35
		TOTAL NUMBER OF CLAIMS	11,430

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
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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SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,552.33	359,333.23	OTHER LAB	134,164.00	0.00
MED/SURG SUPPLY	624,057.91	481.00	RECREATIONAL THERAPY	75,980.00	0.00
LABORATORY-GENERAL	0.00	1,978.00	EDUCATION & TRAINING	0.00	590.00
RADIOLOGY-DIAGNOSTIC	553,601.36	400,511.00	OTHER THERAPEUTIC SVC	113,970.00	342,600.00
CT SCAN	2,054,812.00	954,783.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	728.00	20,783.28	FEE SCHEDULE LAB	4,515,940.75	833,749.25
EKG/ECG	149,649.00	4,286.00	MRI SERVICES	1,808,000.00	1,166,389.00
IV THERAPY	1,330.00	98.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,990,223.34	1,181,019.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,268.00	8,387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	497,888.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	183,607.00	72,055.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,815,818.00	51,591.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	414,275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	563,190.43	487,836.90
RADIOLOGY THERAPEUTIC	1,089,088.00	740,035.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	9,732.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,070.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	87,419.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	108.00	5,252.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,440.00	IMPL DEV CHARGE PATIENTS	241,928.01	1,549,364.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	122,891.00
OTHER IMAGING SERVICE	802,666.00	546,683.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	200,179.00	4,086.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,707.00	219,887.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	773,156.00	580,313.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,306.00	0.00			
ORGAN ACQUISITION	0.00	9,425.00			
TREATMENT/OBSERV. RM	258,096.00	11,736.00			

TOTAL ANCILLARY	20,370,777.13	9,776,804.43
TOTAL ACCOMODATIONS	0.00	1,570.00
TOTAL CHARGES	20,370,777.13	9,778,374.43

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 09/01/17 THROUGH 08/31/18
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	2017281002714	10/03/17 - 10/03/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
8623	5917303000663	09/14/17 - 09/14/17	11/06/17	0.00	71.00	0.00	0.00	0.00
615	2017310037619	10/29/17 - 10/29/17	11/13/17	0.00	4,479.00	0.00	0.00	0.00
615	2017310037619	10/29/17 - 10/29/17	11/13/17	0.00	4,479.00	0.00	0.00	0.00
615	2017321068511	11/11/17 - 11/11/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017323001423	11/10/17 - 11/10/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017323001423	11/10/17 - 11/10/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017332079783	11/18/17 - 11/18/17	12/04/17	0.00	2,698.00	0.00	0.00	0.00
615	2017332079783	11/18/17 - 11/18/17	12/04/17	0.00	2,698.00	0.00	0.00	0.00
615	2017357032380	12/13/17 - 12/13/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	5918011001344	11/28/17 - 11/28/17	01/15/18	0.00	2,698.00	0.00	0.00	0.00
615	5918011001344	11/28/17 - 11/28/17	01/15/18	0.00	2,698.00	0.00	0.00	0.00
615	2018029029960	01/22/18 - 01/22/18	02/05/18	0.00	4,479.00	0.00	0.00	0.00
615	2018047074189	11/27/17 - 11/27/17	02/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018047074189	11/27/17 - 11/27/17	02/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018115068053	04/19/18 - 04/19/18	04/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018123094908	04/27/18 - 04/27/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018123094908	04/27/18 - 04/27/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018124085873	04/23/18 - 04/23/18	05/14/18	0.00	4,479.00	0.00	0.00	0.00
615	2018136070429	05/11/18 - 05/11/18	05/21/18	0.00	4,479.00	0.00	0.00	0.00
615	2018144094059	05/14/18 - 05/14/18	05/28/18	0.00	4,479.00	0.00	0.00	0.00
615	2018156075183	05/29/18 - 05/29/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018156075184	05/29/18 - 05/29/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018164078721	05/31/18 - 05/31/18	06/18/18	0.00	2,698.00	0.00	0.00	0.00
615	2018164078721	05/31/18 - 05/31/18	06/18/18	0.00	2,698.00	0.00	0.00	0.00
615	2018180061978	06/22/18 - 06/22/18	07/09/18	0.00	2,698.00	0.00	0.00	0.00
615	2018186098296	06/27/18 - 06/27/18	07/09/18	0.00	4,479.00	0.00	0.00	0.00
615	5918199001143	06/14/18 - 06/14/18	07/23/18	0.00	4,479.00	0.00	0.00	0.00
615	5918199001143	06/14/18 - 06/14/18	07/23/18	0.00	4,479.00	0.00	0.00	0.00
615	2018219070902	07/31/18 - 07/31/18	08/13/18	0.00	4,479.00	0.00	0.00	0.00
615	2018219070902	07/31/18 - 07/31/18	08/13/18	0.00	4,479.00	0.00	0.00	0.00
615	2218222013533	07/13/18 - 07/13/18	08/13/18	0.00	2,698.00	0.00	0.00	0.00
TOTAL				0.00	122,891.00	0.00	0.00	0.00

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

EMORY 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	861,905.38	ADJUSTMENTS	0.00
COVERED CHARGES	330,280.56	CONTRACTUAL ALLOW	-51,541.03
NON-COVERD CHARGES	531,624.82	TOTAL MEDICAID LIAB	381,821.59
		LESS: COB	381,611.12
		LESS: COPAYMENT	210.47
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 117

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
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,592.36	10,012.13	OTHER LAB	1,872.00	0.00
MED/SURG SUPPLY	17,288.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,070.08	3,190.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,741.00	35,245.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	49,402.00	10,621.00
EKG/ECG	2,772.00	154.00	MRI SERVICES	8,958.00	87,799.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,325.00	75,929.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,478.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,074.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,720.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,979.00	217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,561.12	13,548.94
RADIOLOGY THERAPEUTIC	37,132.00	51,030.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,978.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	175.00	140,856.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,833.00
OTHER IMAGING SERVICE	2,614.00	26,778.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,809.00	2,884.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,147.00	46,956.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	741.00	0.00			
ORGAN ACQUISITION	0.00	1,243.75			
TREATMENT/OBSERV. RM	7,650.00	2,350.00			

TOTAL ANCILLARY	330,280.56	531,624.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	330,280.56	531,624.82

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

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 09/01/17 THROUGH 08/31/18
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	2018095101904	03/17/18 - 03/17/18	04/09/18	0.00	2,698.00	0.00	1,182.66	0.00
615	2018095101904	03/17/18 - 03/17/18	04/09/18	0.00	4,479.00	0.00	1,182.66	0.00
615	2018176022878	06/06/18 - 06/06/18	07/02/18	0.00	2,698.00	0.00	3,905.02	0.00
615	2018176022878	06/06/18 - 06/06/18	07/02/18	0.00	4,479.00	0.00	3,905.02	0.00
615	2019022072538	06/21/18 - 06/21/18	01/28/19	0.00	4,479.00	0.00	625.41	0.00
TOTAL				0.00	18,833.00	0.00	10,800.77	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,180.68	ADJUSTMENTS	892.63
COVERED CHARGES	104,831.42	CONTRACTUAL ALLOW	100,098.87
NON-COVERD CHARGES	13,349.26	TOTAL MEDICAID LIAB	4,732.55
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	4,537.55
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.50	2.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,171.16	819.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,564.00	9,376.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,627.00	478.00
EKG/ECG	1,848.00	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	377.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,103.00	1,895.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,542.76	778.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,087.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	975.00	0.00			

TOTAL ANCILLARY	104,831.42	13,349.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	104,831.42	13,349.26

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,337.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,337.00	CONTRACTUAL ALLOW	499.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	837.23
		LESS: COB	831.23
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

EMORY 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	1,337.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,337.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,337.00	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,597,076.97	ADJUSTMENTS	122,467.11
COVERED CHARGES	1,452,665.95	CONTRACTUAL ALLOW	1,272,037.95
NON-COVERD CHARGES	144,411.02	TOTAL MEDICAID LIAB	180,628.00
		LESS: COB	0.00
		LESS: COPAYMENT	152.89
		REIMBURSEMENT	180,475.11
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,975.00	1,502.73	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,471.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163,187.00	25,412.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,737.00	6,384.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,658.00	3,381.00
EKG/ECG	154.00	154.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	367,326.00	56,531.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,963.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	220,786.09	5,528.29
RADIOLOGY THERAPEUTIC	116,305.00	5,420.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,978.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	278,062.00	19,457.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	310.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,546.00	7,144.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,496.00	9,519.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,452,665.95	144,411.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,452,665.95	144,411.02

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,734,124.67	ADJUSTMENTS	0.00
COVERED CHARGES	4,743,505.67	CONTRACTUAL ALLOW	1,435,538.28
NON-COVERD CHARGES	1,990,619.00	TOTAL MEDICAID LIAB	3,307,967.39
		LESS: COB	2,230.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,305,736.44

TOTAL NUMBER OF ADMISSIONS 320

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,367	0	3,697,254.00	1,990,619.00
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	2,367	0	3,697,254.00	1,990,619.00
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	2,367	0	3,697,254.00	1,990,619.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,529.44	0.00	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	1,390.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	541,134.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,406.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,468.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,464.00	0.00	MRI SERVICES	4,479.00	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	32,454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335,763.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,923.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	33,294.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,788.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,223.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,046,251.67	0.00
TOTAL ACCOMODATIONS	3,697,254.00	1,990,619.00
TOTAL CHARGES	4,743,505.67	1,990,619.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	150,683,852.53	ADJUSTMENTS	8,116,979.58
COVERED CHARGES	148,076,178.49	CONTRACTUAL ALLOW	111,098,519.27
NON-COVERD CHARGES	2,607,674.04	TOTAL MEDICAID LIAB	36,977,659.22
		LESS: COB	280,283.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,697,376.20

TOTAL NUMBER OF ADMISSIONS 2,434

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,746	0	8,470,172.00	1,210,477.00
ROUTINE NURSERY	676	0	824,223.00	265,475.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	36.00
TOTAL ROUTINE	11,422	0	9,294,395.00	1,475,988.00
SPECIAL CARE SERVICES				
CCU	216	0	381,328.00	0.00
ICU	2,600	0	5,369,640.00	21,740.00
NICU	907	0	3,525,509.00	0.00
PED ICU	864	0	3,242,772.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	320	0	1,097,920.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,907	0	13,617,169.00	21,740.00
TOTAL ACCOMODATIONS	16,329	0	22,911,564.00	1,497,728.00

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,683,652.77	81,622.61	OTHER LAB	631,510.00	23,117.00
MED/SURG SUPPLY	13,151,423.00	81,484.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,078,303.64	171,432.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,836,872.00	8,052.00	OTHER THERAPEUTIC SVC	0.00	2,432.00
CT SCAN	3,608,590.00	73,795.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	868,198.02	4,991.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	279,176.00	0.00	MRI SERVICES	1,251,983.00	4,237.00
IV THERAPY	446,617.00	6,998.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,911,470.00	57,913.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	366,945.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,528,702.00	38,860.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,878,404.00	12,868.00	AMBULANCE	0.00	0.00
GI SERVICES	395,431.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,652,085.00	799.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	663,055.00	4,080.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	867,348.98	656.00	INJECTABLE DRUGS	8,678,562.26	45,764.41
RADIOLOGY THERAPEUTIC	127,919.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	491,698.45	3,618.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	363,135.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	302,029.00	76,030.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	344.00	77,380.00	TRAUMA RESPONSE	0.00	209,281.00
PSYCHIATRIC SERVICES	45,925.00	0.00	IMPL DEV CHARGE PATIENTS	9,271,662.00	9,830.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	466,196.00	31,689.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,680,240.00	34,186.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,718.00	4,271.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,969,281.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,030,759.00	44,560.00			
ORGAN ACQUISITION	249,922.00	0.00			
TREATMENT/OBSERV. RM	279,457.00	0.00			

TOTAL ANCILLARY	125,164,614.49	1,109,946.04
TOTAL ACCOMODATIONS	22,911,564.00	1,497,728.00
TOTAL CHARGES	148,076,178.49	2,607,674.04

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,167,893.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,144,166.37	CONTRACTUAL ALLOW	1,389,052.23
NON-COVERD CHARGES	23,726.83	TOTAL MEDICAID LIAB	755,114.14
		LESS: COB	755,114.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	99	0	78,408.00	14,339.00
ROUTINE NURSERY	2	0	990.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	101	0	79,398.00	14,339.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	15	0	25,750.00	0.00
NICU	0	0	0.00	0.00
PED ICU	37	0	143,135.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	6	0	20,586.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	189,471.00	0.00
TOTAL ACCOMODATIONS	159	0	268,869.00	14,339.00

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351,404.62	0.00	OTHER LAB	6,659.00	0.00
MED/SURG SUPPLY	231,655.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	155,673.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,567.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,316.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,264.00	0.00	MRI SERVICES	23,056.00	0.00
IV THERAPY	6,830.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,889.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,993.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	185,954.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,739.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,338.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,468.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	18,395.00	0.00	INJECTABLE DRUGS	21,678.20	2,492.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,277.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,667.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,030.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,403.00	TRAUMA RESPONSE	0.00	4,492.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	412,564.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,685.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,782.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,961.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	89,230.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	502.00	0.00			

TOTAL ANCILLARY	1,875,297.37	9,387.83
TOTAL ACCOMODATIONS	268,869.00	14,339.00
TOTAL CHARGES	2,144,166.37	23,726.83

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,908,899.00	ADJUSTMENTS	3,983,721.29
COVERED CHARGES	58,994,159.64	CONTRACTUAL ALLOW	47,900,894.35
NON-COVERD CHARGES	5,914,739.36	TOTAL MEDICAID LIAB	11,093,265.29
		LESS: COB	38,525.97
		LESS: COPAYMENT	51,978.87
		REIMBURSEMENT	11,002,760.45
		ALL OTHER	8,684,604.74
		FEE SCHEDULE-LAB	825,878.69
		INJECTABLE DRUGS	1,492,277.02

TOTAL NUMBER OF CLAIMS 32,682

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,929,784.35	8,969.19	OTHER LAB	859,820.00	32,158.00
MED/SURG SUPPLY	1,859,485.00	1,796.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	415.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,805,449.00	62,743.00	OTHER THERAPEUTIC SVC	0.00	12,249.00
CT SCAN	2,979,860.00	611,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	107,465.00	49,709.02	FEE SCHEDULE LAB	8,841,167.90	192,180.15
EKG/ECG	214,746.00	2,212.00	MRI SERVICES	2,183,284.00	453,347.00
IV THERAPY	1,008,039.00	52,877.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,653,736.24	667,987.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	508.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	801,327.00	17,862.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,651,132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	483,778.14	206,695.81	CAST ROOM	11,694.00	1,449.00
EMERGENCY ROOM	4,914,614.00	18,160.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,102,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,761,639.81	1,352,437.90
RADIOLOGY THERAPEUTIC	2,927,570.00	74,202.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,198.00	32,478.45	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,827.00	16,890.58	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	25,766.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,086,702.70	526,534.00	TRAUMA RESPONSE	0.00	202,334.00
PSYCHIATRIC SERVICES	76,567.00	29,811.00	IMPL DEV CHARGE PATIENTS	734,509.00	260,458.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	327.00
OTHER IMAGING SERVICE	1,078,504.00	312,539.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	698,697.00	29,290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	488,623.00	99,900.70			
AUDIOLOGY	6,860.00	3,346.00			
CARDIOLOGY	874,745.50	508,357.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	240.00			
E E G	817,974.00	8,321.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	945,473.00	38,899.00			

TOTAL ANCILLARY	58,994,159.64	5,914,739.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,994,159.64	5,914,739.36

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
518	5918065001508	12/06/17 - 12/06/17	03/12/18	0.00	327.00	0.00	0.00	0.00
TOTAL				0.00	327.00	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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,881,642.51	ADJUSTMENTS	0.00
COVERED CHARGES	1,046,654.51	CONTRACTUAL ALLOW	489,703.22
NON-COVERD CHARGES	834,988.00	TOTAL MEDICAID LIAB	556,951.29
		LESS: COB	556,363.29
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 645

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,742.34	2,006.72	OTHER LAB	22,583.00	1,392.00
MED/SURG SUPPLY	61,807.00	2,082.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,406.00	19,336.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,984.00	67,973.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	662.02	FEE SCHEDULE LAB	164,889.80	4,387.00
EKG/ECG	5,730.00	0.00	MRI SERVICES	9,220.00	49,508.00
IV THERAPY	23,946.00	2,968.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,051.06	93,315.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,210.00	304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	78,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,598.00	CAST ROOM	455.00	688.00
EMERGENCY ROOM	114,255.00	5,435.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,237.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,107.81	363,122.82
RADIOLOGY THERAPEUTIC	60,451.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,060.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	991.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,916.00	13,118.00	TRAUMA RESPONSE	0.00	4,492.00
PSYCHIATRIC SERVICES	0.00	182.00	IMPL DEV CHARGE PATIENTS	5,059.00	107,728.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,849.00	40,019.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,272.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,247.00	6,798.00			
AUDIOLOGY	1,372.00	0.00			
CARDIOLOGY	34,347.50	34,299.50			
AMBULATORY SURGERY	328.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,043.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,762.00	8,522.00			

TOTAL ANCILLARY	1,046,654.51	834,988.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,046,654.51	834,988.00

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,015,795.51	ADJUSTMENTS	10,888.00
COVERED CHARGES	2,797,221.88	CONTRACTUAL ALLOW	2,695,621.88
NON-COVERD CHARGES	218,573.63	TOTAL MEDICAID LIAB	101,600.00
		LESS: COB	60.44
		LESS: COPAYMENT	3,576.00
		REIMBURSEMENT	97,963.56
		TOTAL NUMBER OF CLAIMS	2,032

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,754.77	0.00	OTHER LAB	21,787.00	37.00
MED/SURG SUPPLY	19,874.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	156,080.00	16,043.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	288,075.00	45,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	361.00	FEE SCHEDULE LAB	412,955.75	11,342.00
EKG/ECG	22,278.00	0.00	MRI SERVICES	31,678.00	24,790.00
IV THERAPY	106,837.00	6,867.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,025.34	23,472.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,342.00	1,828.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,533,451.00	2,366.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,896.36	41,336.61
RADIOLOGY THERAPEUTIC	3,127.00	829.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	325.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,835.00	1,682.00	TRAUMA RESPONSE	0.00	20,175.00
PSYCHIATRIC SERVICES	0.00	479.00	IMPL DEV CHARGE PATIENTS	446.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,524.00	19,185.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,049.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	140.00			
CARDIOLOGY	666.00	1,332.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,199.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,717.66	0.00			

TOTAL ANCILLARY	2,797,221.88	218,573.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,797,221.88	218,573.63

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,799.12	ADJUSTMENTS	0.00
COVERED CHARGES	61,483.12	CONTRACTUAL ALLOW	38,396.75
NON-COVERD CHARGES	3,316.00	TOTAL MEDICAID LIAB	23,086.37
		LESS: COB	23,047.37
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	38

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,015.12	0.00	OTHER LAB	1,566.00	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	2,571.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,889.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,729.00	78.00
EKG/ECG	316.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,013.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	37,277.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	996.00	1,349.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	61,483.12	3,316.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	61,483.12	3,316.00

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,000,354.81	ADJUSTMENTS	648,720.34
COVERED CHARGES	12,525,096.06	CONTRACTUAL ALLOW	11,105,113.41
NON-COVERD CHARGES	475,258.75	TOTAL MEDICAID LIAB	1,419,982.65
		LESS: COB	4,456.16
		LESS: COPAYMENT	765.00
		REIMBURSEMENT	1,414,761.49
		TOTAL NUMBER OF CLAIMS	239

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,442.52	1,392.00	OTHER LAB	2,330.00	14,305.00
MED/SURG SUPPLY	563,696.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,056.00	28,814.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,018.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,786.00	FEE SCHEDULE LAB	120,643.00	392.00
EKG/ECG	316.00	316.00	MRI SERVICES	0.00	9,364.00
IV THERAPY	34,414.00	1,543.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	878,516.32	170,344.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,212.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,279.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,608.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,626.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,293,277.98	45,105.06
RADIOLOGY THERAPEUTIC	343,972.00	16,440.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,663.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	991.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,785.00	3,977.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,974,119.00	24,022.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,154.00	878.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,924.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,172.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,446,565.24	144,559.76			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,970.00	3,366.00			

TOTAL ANCILLARY	12,525,096.06	475,258.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,525,096.06	475,258.75

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	414,101.10	ADJUSTMENTS	0.00
COVERED CHARGES	178,863.10	CONTRACTUAL ALLOW	9,023.48
NON-COVERD CHARGES	235,238.00	TOTAL MEDICAID LIAB	169,839.62
		LESS: COB	169,836.62
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,100.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,226.00	34.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	706.00	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	158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,154.00	32,154.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,960.00	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	169.00	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	133,192.00	115,906.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	86,952.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	198.00	192.00			

TOTAL ANCILLARY	178,863.10	235,238.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	178,863.10	235,238.00

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,066,890.00	ADJUSTMENTS	3,915.21
COVERED CHARGES	976,517.00	CONTRACTUAL ALLOW	635,442.56
NON-COVERD CHARGES	90,373.00	TOTAL MEDICAID LIAB	341,074.44
		LESS: COB	4,280.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	336,794.02

TOTAL NUMBER OF ADMISSIONS 55

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	211	0	179,777.00	53,471.00
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	179,777.00	53,471.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	25	0	39,375.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	25	0	39,375.00	0.00
TOTAL ACCOMODATIONS	236	0	219,152.00	53,471.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132,236.00	0.00	OTHER LAB	2,007.00	0.00
MED/SURG SUPPLY	70,355.00	15.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	268,433.00	0.00	EDUCATION & TRAINING	1,200.00	0.00
RADIOLOGY-DIAGNOSTIC	18,140.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	100,535.00	6,022.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,898.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,223.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,368.00	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	30,804.00	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	358.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,144.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,166.00	12,970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,604.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,845.00	15,672.00			

TOTAL ANCILLARY	757,365.00	36,902.00
TOTAL ACCOMODATIONS	219,152.00	53,471.00
TOTAL CHARGES	976,517.00	90,373.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,352,497.00	ADJUSTMENTS	22,166.82
COVERED CHARGES	1,228,459.00	CONTRACTUAL ALLOW	993,483.13
NON-COVERD CHARGES	124,038.00	TOTAL MEDICAID LIAB	234,975.87
		LESS: COB	203.25
		LESS: COPAYMENT	1,158.00
		REIMBURSEMENT	233,614.62
		ALL OTHER	220,928.11
		FEE SCHEDULE-LAB	11,205.94
		INJECTABLE DRUGS	1,480.57

TOTAL NUMBER OF CLAIMS 773

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,884.00	24.00	OTHER LAB	9,061.00	0.00
MED/SURG SUPPLY	43,333.00	90.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.00	EDUCATION & TRAINING	0.00	100.00
RADIOLOGY-DIAGNOSTIC	66,632.00	2,620.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,180.00	44,066.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,845.00	7,030.00	FEE SCHEDULE LAB	201,512.00	25,588.00
EKG/ECG	14,818.00	1,434.00	MRI SERVICES	58,155.00	0.00
IV THERAPY	0.00	47.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,707.00	782.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,106.00	1,512.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,436.00	17,264.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	282,976.00	7,631.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,299.00	1,768.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	494.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	154.00
OTHER IMAGING SERVICE	25,465.00	2,861.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,076.00	3,376.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,661.00	2,151.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,219.00	5,426.00			

TOTAL ANCILLARY	1,228,459.00	124,038.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,228,459.00	124,038.00

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 10/01/17 THROUGH 09/30/18
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
6369	2218201016761	03/11/18 - 03/11/18	07/23/18	0.00	40.00	0.00	0.00	0.00
30	2218255012280	09/06/18 - 09/06/18	09/17/18	0.00	114.00	0.00	0.00	0.00
TOTAL				0.00	154.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,621.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,359.00	CONTRACTUAL ALLOW	3,108.19
NON-COVERD CHARGES	262.00	TOTAL MEDICAID LIAB	3,250.81
		LESS: COB	3,250.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	281.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	296.00	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	1,439.00	262.00
EKG/ECG	239.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,784.00	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	320.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,359.00	262.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,359.00	262.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	191,346.00	ADJUSTMENTS	2,687.20
COVERED CHARGES	177,970.00	CONTRACTUAL ALLOW	167,788.76
NON-COVERD CHARGES	13,376.00	TOTAL MEDICAID LIAB	10,181.24
		LESS: COB	41.01
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	9,870.23
		TOTAL NUMBER OF CLAIMS	166

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,999.00	32.00	OTHER LAB	669.00	0.00
MED/SURG SUPPLY	2,580.00	24.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,095.00	7,352.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,989.00	2,701.00
EKG/ECG	717.00	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	532.00	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	111,755.00	592.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,069.00	148.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,022.00	2,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,970.00	13,376.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,970.00	13,376.00

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

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	898.00	ADJUSTMENTS	0.00
COVERED CHARGES	898.00	CONTRACTUAL ALLOW	621.58
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	276.42
		LESS: COB	276.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.00	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	239.00	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	643.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	898.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	898.00	0.00

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

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,629,815.62	ADJUSTMENTS	2,604,496.05
COVERED CHARGES	67,295,948.78	CONTRACTUAL ALLOW	51,192,141.23
NON-COVERD CHARGES	2,333,866.84	TOTAL MEDICAID LIAB	16,103,807.55
		LESS: COB	100,165.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,003,641.72

TOTAL NUMBER OF ADMISSIONS 1,924

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,115	0	3,796,100.00	890,285.00
ROUTINE NURSERY	913	0	797,350.00	14,058.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,028	0	4,593,450.00	904,343.00
SPECIAL CARE SERVICES				
CCU	990	0	816,750.00	0.00
ICU	1,775	0	2,302,885.00	8,250.00
NICU	326	0	701,552.00	0.00
PED ICU	11	0	13,310.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,102	0	3,834,497.00	8,250.00
TOTAL ACCOMODATIONS	11,130	0	8,427,947.00	912,593.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,802,861.25	68,959.37	OTHER LAB	394,671.00	0.00
MED/SURG SUPPLY	5,102,839.62	121,458.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,093,074.31	147,072.23	EDUCATION & TRAINING	1,650.00	0.00
RADIOLOGY-DIAGNOSTIC	936,489.00	5,911.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,007,294.00	23,184.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,878.00	2,270.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,236,669.00	6,076.44	MRI SERVICES	552,472.00	8,012.00
IV THERAPY	489,014.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,108,670.75	56,274.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,048,419.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,471,501.00	74,609.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	889,040.00	3,297.40	AMBULANCE	0.00	375.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,468,023.00	24,389.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	594,628.00	1,896.00	DRUG-SPECIFIC/HOME IV	0.00	81,550.00
LABORATORY PATHOLOGIC	165,122.00	730.00	INJECTABLE DRUGS	4,450,417.50	441,002.00
RADIOLOGY THERAPEUTIC	126.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,987.00	76.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,101.00	1,216.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	331,328.00	45,238.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,542.00	10,392.00	TRAUMA RESPONSE	0.00	56,339.00
PSYCHIATRIC SERVICES	4,950.00	0.00	IMPL DEV CHARGE PATIENTS	2,512,605.25	2,131.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	170,874.00	49,172.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	223,590.00	119,649.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	256,007.00	56,060.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,196,912.10	3,430.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,865.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,381.00	10,505.00			

TOTAL ANCILLARY	58,868,001.78	1,421,273.84
TOTAL ACCOMODATIONS	8,427,947.00	912,593.00
TOTAL CHARGES	67,295,948.78	2,333,866.84

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	463,985.65	ADJUSTMENTS	0.00
COVERED CHARGES	460,214.65	CONTRACTUAL ALLOW	201,489.03
NON-COVERD CHARGES	3,771.00	TOTAL MEDICAID LIAB	258,725.62
		LESS: COB	258,725.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	27,500.00	2,475.00
ROUTINE NURSERY	17	0	21,950.00	781.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	49,450.00	3,256.00
SPECIAL CARE SERVICES				
CCU	1	0	825.00	0.00
ICU	4	0	5,775.00	0.00
NICU	5	0	10,760.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	17,360.00	0.00
TOTAL ACCOMODATIONS	77	0	66,810.00	3,256.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,289.25	0.00	OTHER LAB	7,920.00	0.00
MED/SURG SUPPLY	39,138.65	515.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,036.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	380.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,313.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,799.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,949.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,580.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	659.00	0.00	INJECTABLE DRUGS	3,751.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	456.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	304.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	147.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,169.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	624.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,615.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,927.00	0.00			

TOTAL ANCILLARY	393,404.65	515.00
TOTAL ACCOMODATIONS	66,810.00	3,256.00
TOTAL CHARGES	460,214.65	3,771.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,706,149.53	ADJUSTMENTS	1,588,049.34
COVERED CHARGES	46,082,605.25	CONTRACTUAL ALLOW	39,552,744.50
NON-COVERD CHARGES	2,623,544.28	TOTAL MEDICAID LIAB	6,529,860.75
		LESS: COB	7,015.68
		LESS: COPAYMENT	15,516.69
		REIMBURSEMENT	6,507,328.38
		ALL OTHER	5,905,478.83
		FEE SCHEDULE-LAB	550,548.38
		INJECTABLE DRUGS	51,301.17
		TOTAL NUMBER OF CLAIMS	12,488

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,899,857.15	4,029.00	OTHER LAB	211,280.00	958.00
MED/SURG SUPPLY	2,016,172.64	26,875.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	6,775.00	51,000.00
RADIOLOGY-DIAGNOSTIC	1,448,393.00	24,985.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,287,875.00	105,090.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	165,456.00	30,159.03	FEE SCHEDULE LAB	8,144,810.96	280,877.00
EKG/ECG	883,798.00	5,856.00	MRI SERVICES	708,331.00	41,364.00
IV THERAPY	3,053,388.00	375,750.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,170,139.00	314,277.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	103,549.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	167,445.00	459,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	677,985.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,681,948.00	385,191.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	639,566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	23,940.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,663.75	6,694.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,672.00	2,673.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,596.00	2,660.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	92,381.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	426,815.00	26,908.00	TRAUMA RESPONSE	0.00	6,477.00
PSYCHIATRIC SERVICES	155,100.00	9,075.00	IMPL DEV CHARGE PATIENTS	299,822.75	0.00
LITHOTRIPSY	142,328.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	382,164.00	30,223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	130,226.00	46,371.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	582,935.00	55,536.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	803,679.00	172,219.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	291,780.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,287,055.00	42,333.00			

TOTAL ANCILLARY	46,082,605.25	2,623,544.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,082,605.25	2,623,544.28

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	818,109.75	ADJUSTMENTS	0.00
COVERED CHARGES	663,195.75	CONTRACTUAL ALLOW	265,963.02
NON-COVERD CHARGES	154,914.00	TOTAL MEDICAID LIAB	397,232.73
		LESS: COB	397,144.03
		LESS: COPAYMENT	88.70
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	140

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,735.00	0.00	OTHER LAB	6,471.00	0.00
MED/SURG SUPPLY	48,601.75	617.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,841.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,501.00	35,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,672.00	FEE SCHEDULE LAB	121,943.00	3,301.00
EKG/ECG	4,406.00	0.00	MRI SERVICES	8,014.00	0.00
IV THERAPY	33,870.00	1,309.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,683.00	83,935.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,871.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	686.00	4,594.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	158,866.00	6,499.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,844.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,904.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	152.00	1,444.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,877.00	3,136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,097.00	0.00
LITHOTRIPSY	17,791.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,127.00	11,060.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,205.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,140.00	1,247.00			

TOTAL ANCILLARY	663,195.75	154,914.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	663,195.75	154,914.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,029,018.00	ADJUSTMENTS	1,783.02
COVERED CHARGES	997,603.00	CONTRACTUAL ALLOW	977,632.42
NON-COVERD CHARGES	31,415.00	TOTAL MEDICAID LIAB	19,970.58
		LESS: COB	0.00
		LESS: COPAYMENT	675.00
		REIMBURSEMENT	19,295.58

TOTAL NUMBER OF CLAIMS 357

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,416.50	0.00	OTHER LAB	719.00	0.00
MED/SURG SUPPLY	28,003.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,533.00	2,034.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,594.00	2,024.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	182,725.00	5,632.00
EKG/ECG	6,066.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,566.00	3,366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	564,402.00	17,039.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,979.50	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	936.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,140.00	1,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	997,603.00	31,415.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	997,603.00	31,415.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,794.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,764.50	CONTRACTUAL ALLOW	21,466.83
NON-COVERD CHARGES	1,030.00	TOTAL MEDICAID LIAB	8,297.67
		LESS: COB	8,288.67
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	448.75	0.00	OTHER LAB	800.00	0.00
MED/SURG SUPPLY	682.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,191.00	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	8,251.00	245.00
EKG/ECG	674.00	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	15,914.00	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	363.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	440.00	785.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,764.50	1,030.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,764.50	1,030.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,077,491.05	ADJUSTMENTS	218,509.28
COVERED CHARGES	6,748,117.05	CONTRACTUAL ALLOW	6,074,970.80
NON-COVERD CHARGES	329,374.00	TOTAL MEDICAID LIAB	673,146.25
		LESS: COB	26,248.34
		LESS: COPAYMENT	573.00
		REIMBURSEMENT	646,324.91

TOTAL NUMBER OF CLAIMS 114

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,679,110.05	0.00	OTHER LAB	46,915.00	0.00
MED/SURG SUPPLY	350,271.75	627.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	430.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,543.00	6,764.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,487.00	20,548.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	227,780.00	9,173.00
EKG/ECG	41,294.00	5,055.00	MRI SERVICES	986.00	1,725.00
IV THERAPY	465,511.00	46,218.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,348,209.00	101,960.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,290.00	43,108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	174,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,096.00	3,493.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,373.75	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	3,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	924.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,508,815.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,845.00	875.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,114.00	2,609.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,586.00	6,504.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	391,493.00	55,998.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	739.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	127,710.00	21,287.00			

TOTAL ANCILLARY	6,748,117.05	329,374.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,748,117.05	329,374.00

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

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,918,774.96	ADJUSTMENTS	3,150,887.26
COVERED CHARGES	45,299,940.31	CONTRACTUAL ALLOW	36,059,547.08
NON-COVERD CHARGES	2,618,834.65	TOTAL MEDICAID LIAB	9,240,393.23
		LESS: COB	93,460.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,146,932.68

TOTAL NUMBER OF ADMISSIONS 946

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,626	0	4,290,635.00	959,648.00
ROUTINE NURSERY	1,358	0	2,543,730.00	860,225.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,984	0	6,834,365.00	1,819,873.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	664	0	2,703,412.00	0.00
NICU	216	0	1,418,450.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	880	0	4,121,862.00	0.00
TOTAL ACCOMODATIONS	5,864	0	10,956,227.00	1,819,873.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,734,879.54	173,280.15	OTHER LAB	110,584.00	0.00
MED/SURG SUPPLY	1,500,436.40	27,221.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,837,940.68	100,978.00	EDUCATION & TRAINING	2,860.00	257.00
RADIOLOGY-DIAGNOSTIC	622,528.00	2,828.00	OTHER THERAPEUTIC SVC	0.00	11,328.00
CT SCAN	1,257,502.00	16,512.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	367,633.00	10,284.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165,212.00	736.00	MRI SERVICES	457,257.50	4,291.00
IV THERAPY	39,857.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,717,530.00	19,567.00	DURABLE MED. EQUIP.	0.00	818.00
LABOR/DELIVERY ROOM	1,061,154.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,285,535.77	48,217.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	505,644.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,616.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	825,317.00	2,205.00	SPECIAL SERVICES	0.00	99,595.00
RECOVERY ROOM	301,753.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	65,704.50
LABORATORY PATHOLOGIC	310,310.00	0.00	INJECTABLE DRUGS	6,840,990.50	53,412.00
RADIOLOGY THERAPEUTIC	351,186.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	335,858.00	15,252.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	156,589.00	3,306.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	340,797.00	2,319.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.00	1,158.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,067,330.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	261,840.50	67,917.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	450,304.50	54,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,609.00	10,918.00			
AUDIOLOGY	113,098.00	0.00			
CARDIOLOGY	1,138,243.50	4,146.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,932.00	1,798.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,259.00	0.00			

TOTAL ANCILLARY	34,343,713.31	798,961.65
TOTAL ACCOMODATIONS	10,956,227.00	1,819,873.00
TOTAL CHARGES	45,299,940.31	2,618,834.65

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,228,080.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,152,667.50	CONTRACTUAL ALLOW	548,823.43
NON-COVERD CHARGES	75,413.00	TOTAL MEDICAID LIAB	603,844.07
		LESS: COB	603,844.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	70	0	86,909.00	5,175.00
ROUTINE NURSERY	55	0	128,594.00	55,434.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	125	0	215,503.00	60,609.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	45	0	175,533.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	45	0	175,533.00	0.00
TOTAL ACCOMODATIONS	170	0	391,036.00	60,609.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,422.00	0.00	OTHER LAB	2,790.00	0.00
MED/SURG SUPPLY	43,828.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	143,176.00	0.00	EDUCATION & TRAINING	166.00	0.00
RADIOLOGY-DIAGNOSTIC	11,533.00	0.00	OTHER THERAPEUTIC SVC	0.00	708.00
CT SCAN	15,202.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,789.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,048.00	0.00	MRI SERVICES	5,276.00	0.00
IV THERAPY	531.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,726.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	73,842.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,847.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,096.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,640.00	0.00	SPECIAL SERVICES	0.00	6,735.00
RECOVERY ROOM	17,641.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,757.00	0.00	INJECTABLE DRUGS	86,026.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,660.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,007.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,438.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,582.00	7,361.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,633.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,885.00	0.00			
CARDIOLOGY	21,090.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	761,631.50	14,804.00
TOTAL ACCOMODATIONS	391,036.00	60,609.00
TOTAL CHARGES	1,152,667.50	75,413.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,678,972.64	ADJUSTMENTS	604,987.28
COVERED CHARGES	14,325,651.54	CONTRACTUAL ALLOW	12,395,619.69
NON-COVERD CHARGES	1,353,321.10	TOTAL MEDICAID LIAB	1,930,031.85
		LESS: COB	6,777.13
		LESS: COPAYMENT	5,221.21
		REIMBURSEMENT	1,918,033.51
		ALL OTHER	1,662,839.70
		FEE SCHEDULE-LAB	110,227.57
		INJECTABLE DRUGS	144,966.24

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,716.50	6,053.00	OTHER LAB	264,928.00	0.00
MED/SURG SUPPLY	337,002.00	5,121.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	244.80	EDUCATION & TRAINING	2,151.00	0.00
RADIOLOGY-DIAGNOSTIC	457,653.00	5,096.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,504,060.00	59,921.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,668.00	28,086.00	FEE SCHEDULE LAB	1,683,335.21	68,955.80
EKG/ECG	97,960.00	1,104.00	MRI SERVICES	1,248,395.00	55,045.00
IV THERAPY	206,658.00	16,940.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,440,955.00	140,938.00	DURABLE MED. EQUIP.	0.00	4,457.00
LABOR/DELIVERY ROOM	23,797.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,387.00	4,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	403,643.00	1,324.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343,881.00	51,971.00	SPECIAL SERVICES	0.00	774.00
RECOVERY ROOM	297,227.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	54,787.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,539,968.00	465,561.50
RADIOLOGY THERAPEUTIC	542,279.00	9,876.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,019.00	7,110.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,428.00	4,273.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	193,362.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,252.00	1,570.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,320.00	1,760.00	IMPL DEV CHARGE PATIENTS	153,169.99	2,415.00
LITHOTRIPSY	23,352.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537,157.00	75,677.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,675.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,767.00	12,215.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	198,833.00	27,710.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,191.00	0.00			
ORGAN ACQUISITION	0.00	37,352.00			
TREATMENT/OBSERV. RM	143,951.84	9,549.00			

TOTAL ANCILLARY	14,325,651.54	1,353,321.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,325,651.54	1,353,321.10

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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	575,909.82	ADJUSTMENTS	0.00
COVERED CHARGES	425,242.52	CONTRACTUAL ALLOW	235,737.88
NON-COVERD CHARGES	150,667.30	TOTAL MEDICAID LIAB	189,504.64
		LESS: COB	189,429.64
		LESS: COPAYMENT	75.00
		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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,818.00	196.50	OTHER LAB	16,169.00	0.00
MED/SURG SUPPLY	5,456.00	759.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	244.80	EDUCATION & TRAINING	225.00	0.00
RADIOLOGY-DIAGNOSTIC	17,375.00	2,507.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,469.00	12,062.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,599.00	FEE SCHEDULE LAB	70,718.52	10,982.00
EKG/ECG	4,434.00	736.00	MRI SERVICES	4,291.00	9,720.00
IV THERAPY	3,693.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,749.00	44,334.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,934.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,490.00	171.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,439.00	2,243.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,104.00	8,130.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,756.00	1,214.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,783.00	30,844.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	193.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	880.00	440.00	IMPL DEV CHARGE PATIENTS	1,458.00	345.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,825.00	7,656.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	16,484.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,983.00	0.00			

TOTAL ANCILLARY	425,242.52	150,667.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	425,242.52	150,667.30

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	257,237.00	ADJUSTMENTS	1,660.81
COVERED CHARGES	234,960.00	CONTRACTUAL ALLOW	227,318.54
NON-COVERD CHARGES	22,277.00	TOTAL MEDICAID LIAB	7,641.46
		LESS: COB	43.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	7,418.46

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,668.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	138.00	390.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,238.00	2,445.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,447.00	11,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,488.00	215.00
EKG/ECG	1,840.00	0.00	MRI SERVICES	10,552.00	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	1,494.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,048.00	3,304.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,455.50	1,243.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,573.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	183.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,591.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	234,960.00	22,277.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	234,960.00	22,277.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,540.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,065.50	CONTRACTUAL ALLOW	19,046.97
NON-COVERD CHARGES	475.00	TOTAL MEDICAID LIAB	6,018.53
		LESS: COB	6,006.53
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164.00	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	551.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,172.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,833.00	33.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,551.00	442.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,794.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,065.50	475.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,065.50	475.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,073,198.70	ADJUSTMENTS	53,991.30
COVERED CHARGES	1,889,847.20	CONTRACTUAL ALLOW	1,697,745.76
NON-COVERD CHARGES	183,351.50	TOTAL MEDICAID LIAB	192,101.44
		LESS: COB	0.00
		LESS: COPAYMENT	122.25
		REIMBURSEMENT	191,979.19

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,582.50	0.00	OTHER LAB	265.00	0.00
MED/SURG SUPPLY	99,026.00	240.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,911.00	29,037.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,911.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,060.00	FEE SCHEDULE LAB	27,134.00	1,587.00
EKG/ECG	4,434.00	736.00	MRI SERVICES	4,291.00	0.00
IV THERAPY	15,803.00	382.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	394,637.00	101,694.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	996.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,151.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,456.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	489,573.50	28,528.50
RADIOLOGY THERAPEUTIC	72,163.00	3,965.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,283.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	418.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	532,272.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,521.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	860.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,928.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	115,155.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,855.20	0.00			

TOTAL ANCILLARY	1,889,847.20	183,351.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,889,847.20	183,351.50

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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,182.00	ADJUSTMENTS	0.00
COVERED CHARGES	55,509.00	CONTRACTUAL ALLOW	34,970.50
NON-COVERD CHARGES	23,673.00	TOTAL MEDICAID LIAB	20,538.50
		LESS: COB	20,529.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,394.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,281.00	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	2,980.00	197.00
EKG/ECG	368.00	736.00	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	1,984.00	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	2,990.00	11,527.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,329.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	597.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,399.00	11,213.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,187.00	0.00			

TOTAL ANCILLARY	55,509.00	23,673.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,509.00	23,673.00

** END OF REPORT **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,173,562.92	ADJUSTMENTS	1,464,080.08
COVERED CHARGES	4,121,877.64	CONTRACTUAL ALLOW	1,870,543.92
NON-COVERD CHARGES	51,685.28	TOTAL MEDICAID LIAB	2,251,333.72
		LESS: COB	37,166.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,214,167.44

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,310	0	1,754,040.00	14,850.00
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	1,310	0	1,754,040.00	14,850.00
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	1,310	0	1,754,040.00	14,850.00

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338,681.30	2,621.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55,012.16	1,714.00	RECREATIONAL THERAPY	119.00	0.00
LABORATORY-GENERAL	139,976.90	8,552.92	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,552.00	515.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,201.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	684,874.47	7,840.08	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,477.44	0.00	MRI SERVICES	2,978.13	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	28,960.98	731.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,555.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,076.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	835,953.62	7,043.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	208,929.74	4,152.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	31,000.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	4,710.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,666.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	779.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,367,837.64	36,835.28
TOTAL ACCOMODATIONS	1,754,040.00	14,850.00
TOTAL CHARGES	4,121,877.64	51,685.28

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	171,244,544.55	ADJUSTMENTS	4,272,306.47
COVERED CHARGES	164,031,309.18	CONTRACTUAL ALLOW	140,088,992.87
NON-COVERD CHARGES	7,213,235.37	TOTAL MEDICAID LIAB	23,942,316.31
		LESS: COB	139,810.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,802,505.90

TOTAL NUMBER OF ADMISSIONS 2,489

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,497	0	13,244,058.00	1,548,980.20
ROUTINE NURSERY	2,229	0	4,186,717.50	40,285.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,726	0	17,430,775.50	1,589,265.20
SPECIAL CARE SERVICES				
CCU	848	0	2,177,716.20	0.00
ICU	4,587	0	16,476,742.60	176,507.40
NICU	195	0	711,171.60	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	267	0	1,528,075.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,897	0	20,893,705.40	176,507.40
TOTAL ACCOMODATIONS	16,623	0	38,324,480.90	1,765,772.60

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,675,452.58	1,109,987.08	OTHER LAB	665,999.97	6,300.50
MED/SURG SUPPLY	7,752,341.70	258,464.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,824,336.00	180,940.39	EDUCATION & TRAINING	13,308.00	0.00
RADIOLOGY-DIAGNOSTIC	3,475,158.90	40,467.55	OTHER THERAPEUTIC SVC	0.00	6,880.00
CT SCAN	7,520,397.90	384,293.57	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,170,453.47	61,857.19	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	634,701.98	3,296.09	MRI SERVICES	2,146,433.25	16,012.56
IV THERAPY	720,665.68	1,287.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,656,452.01	255,233.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,910,736.09	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,232,942.70	88,637.99	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,529,534.37	71,602.43	AMBULANCE	0.00	0.00
GI SERVICES	203,614.65	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,376,310.23	49,040.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,580,920.82	15,919.46	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	580,117.18	3,604.78	INJECTABLE DRUGS	145.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	712,578.03	37,865.76	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511,032.15	5,234.65	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,751,957.86	33,977.13	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44,889.00	340.40	TRAUMA RESPONSE	0.00	2,089,750.07
PSYCHIATRIC SERVICES	467,684.35	0.00	IMPL DEV CHARGE PATIENTS	5,508,911.75	58,669.57
LITHOTRIPSY	74,983.04	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	770,029.62	1,200.79			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,024,438.07	621,480.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,043,370.15	10,410.00			
AUDIOLOGY	162,372.92	0.00			
CARDIOLOGY	2,520,410.14	34,343.17			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	217,644.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	226,503.71	365.00			

TOTAL ANCILLARY	125,706,828.28	5,447,462.77
TOTAL ACCOMODATIONS	38,324,480.90	1,765,772.60
TOTAL CHARGES	164,031,309.18	7,213,235.37

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	500,513.41	ADJUSTMENTS	0.00
COVERED CHARGES	476,803.61	CONTRACTUAL ALLOW	364,098.68
NON-COVERD CHARGES	23,709.80	TOTAL MEDICAID LIAB	112,704.93
		LESS: COB	112,704.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	58,818.00	2,440.80
ROUTINE NURSERY	7	0	4,631.40	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	0	63,449.40	2,440.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1	0	3,422.00	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	0	3,422.00	0.00
TOTAL ACCOMODATIONS	47	0	66,871.40	2,440.80

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,855.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,105.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,759.16	0.00	EDUCATION & TRAINING	320.00	0.00
RADIOLOGY-DIAGNOSTIC	2,545.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,337.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,559.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,824.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	114,797.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,316.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,430.37	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,799.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,336.00	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	442.20	691.00	TRAUMA RESPONSE	0.00	20,578.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,414.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,788.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,356.92	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	196.64	0.00			

TOTAL ANCILLARY	409,932.21	21,269.00
TOTAL ACCOMODATIONS	66,871.40	2,440.80
TOTAL CHARGES	476,803.61	23,709.80

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,429,890.03	ADJUSTMENTS	535,686.29
COVERED CHARGES	36,808,520.50	CONTRACTUAL ALLOW	33,516,924.58
NON-COVERD CHARGES	3,621,369.53	TOTAL MEDICAID LIAB	3,291,595.92
		LESS: COB	3,000.66
		LESS: COPAYMENT	6,029.62
		REIMBURSEMENT	3,282,565.64
		ALL OTHER	3,029,398.15
		FEE SCHEDULE-LAB	219,411.05
		INJECTABLE DRUGS	33,756.44

TOTAL NUMBER OF CLAIMS 8,441

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,137,498.01	609.02	OTHER LAB	244,505.76	1,990.00
MED/SURG SUPPLY	1,249,296.97	10,010.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,318,011.00	160,838.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,726,630.85	653,017.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,095.31	19,774.40	FEE SCHEDULE LAB	4,950,731.45	103,635.82
EKG/ECG	691,560.61	7,003.48	MRI SERVICES	802,909.13	87,030.83
IV THERAPY	1,556,317.20	77,208.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,998,445.61	503,084.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	684.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,531.73	17,643.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,040,343.24	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,445.49	3,379.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,625,781.72	121,319.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	331,058.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,865.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,596.27	409,383.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,782.35	9,295.22	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,971.36	1,644.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	308,766.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	95,920.24	10,911.23	TRAUMA RESPONSE	0.00	400,182.90
PSYCHIATRIC SERVICES	266,129.64	95,290.49	IMPL DEV CHARGE PATIENTS	180,181.87	11,894.70
LITHOTRIPSY	524,881.28	299,932.16	NO CC/INVALID REV CODE	77.00	80.00
OTHER IMAGING SERVICE	948,851.97	212,638.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,836.66	7,457.82			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	386,595.06	9,717.00			
AUDIOLOGY	13,440.54	2,135.97			
CARDIOLOGY	182,138.00	21,925.67			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	256,329.02	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	711,942.56	46,704.52			

TOTAL ANCILLARY	36,808,520.50	3,621,369.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,808,520.50	3,621,369.53

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	5918171001287	03/27/18 - 03/27/18	06/25/18	77.00	0.00	0.00	0.00	20.52
780	5918171001287	03/27/18 - 03/27/18	06/25/18	0.00	80.00	0.00	0.00	0.00
TOTAL				77.00	80.00	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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	146,455.30	ADJUSTMENTS	0.00
COVERED CHARGES	86,296.30	CONTRACTUAL ALLOW	56,659.16
NON-COVERD CHARGES	60,159.00	TOTAL MEDICAID LIAB	29,637.14
		LESS: COB	29,632.23
		LESS: COPAYMENT	4.91
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920.33	420.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,333.40	860.72	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,789.05	20,736.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	512.03	FEE SCHEDULE LAB	10,052.76	160.00
EKG/ECG	470.87	0.00	MRI SERVICES	6,133.00	4,512.00
IV THERAPY	2,111.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	21,403.37	250.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,013.72	283.50
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	20,578.00
PSYCHIATRIC SERVICES	0.00	766.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,677.00	10,053.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,343.80	805.00			

TOTAL ANCILLARY	86,296.30	60,159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,296.30	60,159.00

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,648,690.10	ADJUSTMENTS	747.16
COVERED CHARGES	1,585,357.76	CONTRACTUAL ALLOW	1,549,130.56
NON-COVERD CHARGES	63,332.34	TOTAL MEDICAID LIAB	36,227.20
		LESS: COB	985.00
		LESS: COPAYMENT	1,461.00
		REIMBURSEMENT	33,781.20

TOTAL NUMBER OF CLAIMS 630

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,954.47	0.00	OTHER LAB	8,717.98	0.00
MED/SURG SUPPLY	11,010.68	158.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,573.55	12,328.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	206,330.01	31,828.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	291,497.12	1,995.33
EKG/ECG	22,788.97	0.00	MRI SERVICES	19,100.78	0.00
IV THERAPY	72,628.70	1,015.16	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	779,067.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,675.97	2,226.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	196.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,217.47	4,596.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,794.73	8,988.02			
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	0.00	0.00			

TOTAL ANCILLARY	1,585,357.76	63,332.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,585,357.76	63,332.34

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,312.37	ADJUSTMENTS	0.00
COVERED CHARGES	15,274.37	CONTRACTUAL ALLOW	13,222.36
NON-COVERD CHARGES	38.00	TOTAL MEDICAID LIAB	2,052.01
		LESS: COB	2,046.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.25	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	859.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,275.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,243.00	38.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,881.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,274.37	38.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,274.37	38.00

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,945,198.11	ADJUSTMENTS	36,794.16
COVERED CHARGES	1,815,697.06	CONTRACTUAL ALLOW	1,699,134.72
NON-COVERD CHARGES	129,501.05	TOTAL MEDICAID LIAB	116,562.34
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	116,487.34

TOTAL NUMBER OF CLAIMS 19

GEORGIA 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 ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,279.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	213,514.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,304.37	594.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,284.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,073.77	FEE SCHEDULE LAB	22,408.02	0.00
EKG/ECG	2,825.22	0.00	MRI SERVICES	6,513.39	0.00
IV THERAPY	2,839.14	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	315,039.92	83,457.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,777.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,457.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,843.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,132.74	18,846.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	662,371.96	0.00
LITHOTRIPSY	149,966.08	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,255.86	25,528.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,706.68	0.00			

TOTAL ANCILLARY	1,815,697.06	129,501.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,815,697.06	129,501.05

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,302,181.24	ADJUSTMENTS	57,046.48
COVERED CHARGES	2,279,316.24	CONTRACTUAL ALLOW	1,447,775.04
NON-COVERD CHARGES	22,865.00	TOTAL MEDICAID LIAB	831,541.20
		LESS: COB	3,486.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	828,054.28

TOTAL NUMBER OF ADMISSIONS 121

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	349	0	369,037.00	19,412.00
ROUTINE NURSERY	51	0	49,521.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	400	0	418,558.00	19,412.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	103	0	221,965.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	103	0	221,965.00	0.00
TOTAL ACCOMODATIONS	503	0	640,523.00	19,412.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490,213.28	0.00	OTHER LAB	7,259.00	0.00
MED/SURG SUPPLY	216,650.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	214,488.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	93,950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,171.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,685.00	0.00	MRI SERVICES	17,580.00	0.00
IV THERAPY	45,093.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	161,140.00	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	75,773.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,002.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,681.00	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	2,397.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,864.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,018.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,490.00	3,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,367.00	0.00			
AUDIOLOGY	6,336.00	0.00			
CARDIOLOGY	16,928.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,891.00	0.00			

TOTAL ANCILLARY	1,638,793.24	3,453.00
TOTAL ACCOMODATIONS	640,523.00	19,412.00
TOTAL CHARGES	2,279,316.24	22,865.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,120.78	ADJUSTMENTS	0.00
COVERED CHARGES	70,784.78	CONTRACTUAL ALLOW	20,951.38
NON-COVERD CHARGES	3,336.00	TOTAL MEDICAID LIAB	49,833.40
		LESS: COB	49,833.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	21	0	22,260.00	1,034.00
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	22,260.00	1,034.00
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	22,260.00	1,034.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,718.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,865.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,472.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,762.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	149.00	0.00	MRI SERVICES	2,700.00	0.00
IV THERAPY	932.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,613.00	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	1,207.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	632.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,698.00	2,302.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	747.00	0.00			

TOTAL ANCILLARY	48,524.78	2,302.00
TOTAL ACCOMODATIONS	22,260.00	1,034.00
TOTAL CHARGES	70,784.78	3,336.00

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 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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,992,072.28	ADJUSTMENTS	205,278.05
COVERED CHARGES	2,656,277.75	CONTRACTUAL ALLOW	1,905,161.65
NON-COVERD CHARGES	335,794.53	TOTAL MEDICAID LIAB	751,116.10
		LESS: COB	1,685.91
		LESS: COPAYMENT	2,103.29
		REIMBURSEMENT	747,326.90
		ALL OTHER	597,079.77
		FEE SCHEDULE-LAB	67,428.70
		INJECTABLE DRUGS	82,818.43

TOTAL NUMBER OF CLAIMS 2,109

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,068.44	1,056.60	OTHER LAB	46,964.00	8,665.00
MED/SURG SUPPLY	61,427.59	43.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	174.00	58.00
RADIOLOGY-DIAGNOSTIC	148,360.00	2,924.00	OTHER THERAPEUTIC SVC	252.00	1,851.00
CT SCAN	269,413.00	26,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,728.00	5,336.02	FEE SCHEDULE LAB	371,513.48	25,600.50
EKG/ECG	34,507.00	745.00	MRI SERVICES	91,824.00	9,384.00
IV THERAPY	125,447.00	17,366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,649.50	6,593.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,261.00	3,057.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,890.00	9,512.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,738.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	575,562.00	13,865.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,802.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285,871.41	69,977.24
RADIOLOGY THERAPEUTIC	177,577.00	102,988.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	177.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,496.00	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	NO CC/INVALID REV CODE	0.00	52.00
OTHER IMAGING SERVICE	85,483.00	14,894.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,366.00	2,592.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,318.00	2,515.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,682.00	600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,598.33	9,389.67			

TOTAL ANCILLARY	2,656,277.75	335,794.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,656,277.75	335,794.53

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 05/01/17 THROUGH 04/30/18
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
8369	2218040009414	11/03/17 - 11/03/17	02/12/18	0.00	52.00	0.00	0.00	0.00
TOTAL				0.00	52.00	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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,931.74	ADJUSTMENTS	0.00
COVERED CHARGES	38,682.24	CONTRACTUAL ALLOW	14,845.96
NON-COVERD CHARGES	9,249.50	TOTAL MEDICAID LIAB	23,836.28
		LESS: COB	23,815.28
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,213.19	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	125.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,032.00	397.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,766.00	3,893.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,831.00	263.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,379.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	449.00	426.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	471.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,565.00	1,711.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	680.05	1,218.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	586.00	1,341.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,163.00	0.00			

TOTAL ANCILLARY	38,682.24	9,249.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,682.24	9,249.50

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	175,586.27	ADJUSTMENTS	806.10
COVERED CHARGES	166,579.77	CONTRACTUAL ALLOW	155,503.65
NON-COVERD CHARGES	9,006.50	TOTAL MEDICAID LIAB	11,076.12
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	10,749.12
		TOTAL NUMBER OF CLAIMS	198

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,235.00	0.00	OTHER LAB	0.00	1,602.00
MED/SURG SUPPLY	911.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,564.00	823.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,193.00	2,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,642.00	1,408.00
EKG/ECG	1,043.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	7,404.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	314.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,430.00	725.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,424.80	1,259.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,558.00	755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,000.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	166,579.77	9,006.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	166,579.77	9,006.50

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,686.10	ADJUSTMENTS	0.00
COVERED CHARGES	2,670.10	CONTRACTUAL ALLOW	1,401.56
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	1,268.54
		LESS: COB	1,262.54
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	213.00	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	451.00	16.00
EKG/ECG	149.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	340.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,348.00	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	108.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,670.10	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,670.10	16.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	140,466.98	ADJUSTMENTS	29,178.34
COVERED CHARGES	136,808.78	CONTRACTUAL ALLOW	101,628.30
NON-COVERD CHARGES	3,658.20	TOTAL MEDICAID LIAB	35,180.48
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	35,153.48

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,410.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	433.00	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	123.00
CT SCAN	1,459.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,201.00	180.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,080.00	914.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,597.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86,334.00	36.20
RADIOLOGY THERAPEUTIC	3,883.00	303.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,062.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,994.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	930.00	2,102.00			

TOTAL ANCILLARY	136,808.78	3,658.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,808.78	3,658.20

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,666,469.99	ADJUSTMENTS	909,462.80
COVERED CHARGES	30,019,498.90	CONTRACTUAL ALLOW	20,448,495.15
NON-COVERD CHARGES	646,971.09	TOTAL MEDICAID LIAB	9,571,003.75
		LESS: COB	38,311.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,532,692.64

TOTAL NUMBER OF ADMISSIONS 905

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,699	0	3,893,819.00	393,669.00
ROUTINE NURSERY	222	0	215,651.00	72.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,921	0	4,109,470.00	393,741.00
SPECIAL CARE SERVICES				
CCU	364	0	785,663.00	0.00
ICU	1,940	0	3,343,940.00	0.00
NICU	8	0	14,064.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,312	0	4,143,667.00	0.00
TOTAL ACCOMODATIONS	6,233	0	8,253,137.00	393,741.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,209,605.55	10.20	OTHER LAB	106,245.00	0.00
MED/SURG SUPPLY	2,047,054.76	6,364.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,393,565.54	4,327.00	EDUCATION & TRAINING	1,588.00	0.00
RADIOLOGY-DIAGNOSTIC	460,129.00	0.00	OTHER THERAPEUTIC SVC	0.00	366.00
CT SCAN	467,879.00	176,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	211,740.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	112,579.00	0.00	MRI SERVICES	293,384.00	0.00
IV THERAPY	614,326.00	2,069.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,584,818.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	167,965.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,234,858.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	484,201.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408,544.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	190,627.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	107,348.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	212,684.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	44,700.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	343,302.00	2,302.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,091.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,900.00
OTHER IMAGING SERVICE	72,786.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	448,041.00	38,041.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,656.89	4,024.89			
AUDIOLOGY	26,928.00	0.00			
CARDIOLOGY	1,120,290.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,638.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	266,788.00	0.00			

TOTAL ANCILLARY	21,766,361.90	253,230.09
TOTAL ACCOMODATIONS	8,253,137.00	393,741.00
TOTAL CHARGES	30,019,498.90	646,971.09

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 05/01/17 THROUGH 04/30/18
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	2017189003001	06/27/17 - 06/30/17	07/17/17	0.00	2,700.00	0.00	0.00	0.00
615	2218024000648	01/09/18 - 01/14/18	01/29/18	0.00	2,700.00	0.00	0.00	0.00
615	2018041000181	01/03/18 - 01/05/18	02/19/18	0.00	2,700.00	0.00	0.00	0.00
615	2218080000736	03/02/18 - 03/15/18	03/26/18	0.00	2,700.00	0.00	0.00	0.00
615	2218144014388	04/29/18 - 05/14/18	05/28/18	0.00	2,700.00	0.00	0.00	0.00
615	2018265025635	05/24/17 - 05/26/17	10/01/18	0.00	2,700.00	0.00	0.00	0.00
615	2019107012250	03/05/18 - 03/07/18	04/22/19	0.00	2,700.00	0.00	0.00	0.00
TOTAL				0.00	18,900.00	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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,030.79	ADJUSTMENTS	0.00
COVERED CHARGES	190,177.79	CONTRACTUAL ALLOW	55,407.20
NON-COVERD CHARGES	7,853.00	TOTAL MEDICAID LIAB	134,770.59
		LESS: COB	134,770.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	37	0	38,905.00	2,620.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	37	0	38,905.00	2,620.00
SPECIAL CARE SERVICES				
CCU	1	0	2,155.00	0.00
ICU	5	0	8,110.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	10,265.00	0.00
TOTAL ACCOMODATIONS	43	0	49,170.00	2,620.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,521.29	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,685.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,143.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,170.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,918.00	1,780.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	632.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,398.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,862.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	432.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,045.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,232.00	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	3,797.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	462.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,396.00	3,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,673.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,035.00	0.00			

TOTAL ANCILLARY	141,007.79	5,233.00
TOTAL ACCOMODATIONS	49,170.00	2,620.00
TOTAL CHARGES	190,177.79	7,853.00

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 SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,627,057.04	ADJUSTMENTS	860,449.00
COVERED CHARGES	10,245,069.86	CONTRACTUAL ALLOW	7,406,750.77
NON-COVERD CHARGES	1,381,987.18	TOTAL MEDICAID LIAB	2,838,319.09
		LESS: COB	2,150.71
		LESS: COPAYMENT	8,074.48
		REIMBURSEMENT	2,828,093.90
		ALL OTHER	2,155,188.92
		FEE SCHEDULE-LAB	233,753.07
		INJECTABLE DRUGS	439,151.91

TOTAL NUMBER OF CLAIMS 6,342

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,581.53	7,297.79	OTHER LAB	156,927.00	19,733.00
MED/SURG SUPPLY	471,483.38	849.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	155.00	EDUCATION & TRAINING	116.00	59.00
RADIOLOGY-DIAGNOSTIC	466,687.00	15,833.00	OTHER THERAPEUTIC SVC	878.00	7,889.00
CT SCAN	838,557.00	223,313.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,339.00	21,059.06	FEE SCHEDULE LAB	1,222,307.00	74,211.00
EKG/ECG	98,372.00	2,384.00	MRI SERVICES	306,618.00	37,876.00
IV THERAPY	387,864.00	16,882.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	723,736.42	148,794.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,117.00	12,796.00	REHAB THERAPY	1,008.00	0.00
RESPIRATORY SERVICES	220,453.00	14,564.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,962.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,777.00	2,258.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,402,457.00	22,114.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,506.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,599.42	239,064.17
RADIOLOGY THERAPEUTIC	751,822.00	277,797.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,655.00	5,310.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,849.00	1,818.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,426.00	1,500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,016.00	969.00
LITHOTRIPSY	30,393.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	402,356.00	41,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,157.00	1,296.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	111,555.00	15,192.57			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,895.00	143,907.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,880.00	564.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	324,720.11	25,265.91			

TOTAL ANCILLARY	10,245,069.86	1,381,987.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,245,069.86	1,381,987.18

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	273,208.47	ADJUSTMENTS	0.00
COVERED CHARGES	193,439.27	CONTRACTUAL ALLOW	52,338.00
NON-COVERD CHARGES	79,769.20	TOTAL MEDICAID LIAB	141,101.27
		LESS: COB	140,924.76
		LESS: COPAYMENT	176.51
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 100

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,723.02	72.40	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	17,962.00	292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,519.00	0.00	OTHER THERAPEUTIC SVC	0.00	126.00
CT SCAN	20,781.00	13,659.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,221.00	2,023.00
EKG/ECG	2,086.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,000.00	1,558.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,441.00	23,499.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,845.00	2,078.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	471.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,060.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,146.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,719.00	630.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,835.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,454.25	13,368.80
RADIOLOGY THERAPEUTIC	3,701.00	7,920.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,950.00	6,753.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,994.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,640.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,215.00	4,004.00			

TOTAL ANCILLARY	193,439.27	79,769.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	193,439.27	79,769.20

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	536,897.48	ADJUSTMENTS	1,543.48
COVERED CHARGES	502,672.88	CONTRACTUAL ALLOW	473,584.08
NON-COVERD CHARGES	34,224.60	TOTAL MEDICAID LIAB	29,088.80
		LESS: COB	12.78
		LESS: COPAYMENT	1,032.00
		REIMBURSEMENT	28,044.02

TOTAL NUMBER OF CLAIMS 520

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,825.43	146.40	OTHER LAB	1,848.00	0.00
MED/SURG SUPPLY	8,647.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,671.00	949.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,966.00	17,583.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,872.00	426.00	FEE SCHEDULE LAB	79,014.00	6,218.00
EKG/ECG	7,301.00	0.00	MRI SERVICES	1,860.00	3,720.00
IV THERAPY	18,862.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	591.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,711.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	238,515.00	504.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,457.45	1,981.20
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,530.00	924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,849.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,182.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,163.00	0.00			

TOTAL ANCILLARY	502,672.88	34,224.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	502,672.88	34,224.60

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,505.60	ADJUSTMENTS	0.00
COVERED CHARGES	6,457.60	CONTRACTUAL ALLOW	2,907.37
NON-COVERD CHARGES	48.00	TOTAL MEDICAID LIAB	3,550.23
		LESS: COB	3,547.23
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121.00	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	993.00	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	796.00	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	554.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,375.00	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	108.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,510.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,457.60	48.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,457.60	48.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,816,610.61	ADJUSTMENTS	159,467.37
COVERED CHARGES	1,652,978.70	CONTRACTUAL ALLOW	1,334,782.35
NON-COVERD CHARGES	163,631.91	TOTAL MEDICAID LIAB	318,196.35
		LESS: COB	0.00
		LESS: COPAYMENT	431.37
		REIMBURSEMENT	317,764.98
		TOTAL NUMBER OF CLAIMS	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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,939.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	455,881.26	3,742.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	236.00
RADIOLOGY-DIAGNOSTIC	17,308.00	22,230.00	OTHER THERAPEUTIC SVC	126.00	504.00
CT SCAN	2,755.00	3,040.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	203.00	FEE SCHEDULE LAB	11,189.00	2,087.00
EKG/ECG	1,639.00	1,192.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,069.00	498.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	399,040.66	5,522.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,180.00	1,892.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,324.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,516.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,836.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285,550.85	14,221.57
RADIOLOGY THERAPEUTIC	209,795.00	31,523.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	408.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,992.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	804.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,168.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	120,381.00	73,418.00			
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	17,484.20	2,915.00			

TOTAL ANCILLARY	1,652,978.70	163,631.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,652,978.70	163,631.91

GEORGIA DEPARTMENT OF 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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,451.82	ADJUSTMENTS	0.00
COVERED CHARGES	21,563.02	CONTRACTUAL ALLOW	8,787.11
NON-COVERD CHARGES	888.80	TOTAL MEDICAID LIAB	12,775.91
		LESS: COB	12,769.91
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	926.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,607.00	146.00	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	289.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,390.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	856.00	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	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277.70	720.80
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,563.02	888.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,563.02	888.80

** 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,718,985.22	ADJUSTMENTS	95,503.72
COVERED CHARGES	14,204,391.24	CONTRACTUAL ALLOW	11,429,354.75
NON-COVERD CHARGES	514,593.98	TOTAL MEDICAID LIAB	2,775,036.49
		LESS: COB	34,447.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,740,588.76

TOTAL NUMBER OF ADMISSIONS 327

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	578	0	527,481.00	167,741.43
ROUTINE NURSERY	90	0	81,457.21	2,727.42
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	668	0	608,938.21	170,468.85
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	601	0	1,602,042.67	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	601	0	1,602,042.67	0.00
TOTAL ACCOMODATIONS	1,269	0	2,210,980.88	170,468.85

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	523,084.93	0.00	OTHER LAB	17,381.49	0.00
MED/SURG SUPPLY	182,962.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,982,029.27	0.00	EDUCATION & TRAINING	224.00	0.00
RADIOLOGY-DIAGNOSTIC	202,159.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,938.25	319,218.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,348.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226,998.16	0.00	MRI SERVICES	78,161.85	0.00
IV THERAPY	100,528.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,246,935.79	2,163.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	210,657.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,325,193.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	444,002.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,824.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,321.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	105,592.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	118,671.80	0.00	INJECTABLE DRUGS	1,922,805.04	0.00
RADIOLOGY THERAPEUTIC	42,316.01	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,919.65	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.74	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,111,384.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,051.55	8,102.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,958.00	3,912.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	90,045.20	10,728.15			
AUDIOLOGY	8,810.08	0.00			
CARDIOLOGY	274,789.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,326.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,844.83	0.00			

TOTAL ANCILLARY	11,993,410.36	344,125.13
TOTAL ACCOMODATIONS	2,210,980.88	170,468.85
TOTAL CHARGES	14,204,391.24	514,593.98

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,451.67	ADJUSTMENTS	0.00
COVERED CHARGES	11,081.10	CONTRACTUAL ALLOW	4,504.80
NON-COVERD CHARGES	370.57	TOTAL MEDICAID LIAB	6,576.30
		LESS: COB	6,576.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	870.00	370.57
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	870.00	370.57
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	870.00	370.57

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	665.90	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	7,802.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,248.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,211.10	0.00
TOTAL ACCOMODATIONS	870.00	370.57
TOTAL CHARGES	11,081.10	370.57

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,573,374.72	ADJUSTMENTS	233,435.90
COVERED CHARGES	15,657,386.14	CONTRACTUAL ALLOW	13,923,857.97
NON-COVERD CHARGES	2,915,988.58	TOTAL MEDICAID LIAB	1,733,528.17
		LESS: COB	3,908.62
		LESS: COPAYMENT	6,010.21
		REIMBURSEMENT	1,723,609.34
		ALL OTHER	1,445,725.65
		FEE SCHEDULE-LAB	168,048.16
		INJECTABLE DRUGS	109,835.53

TOTAL NUMBER OF CLAIMS 5,045

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,561.34	55,964.25	OTHER LAB	45,064.10	0.00
MED/SURG SUPPLY	174,314.90	869.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	44.80
RADIOLOGY-DIAGNOSTIC	557,949.85	36,486.00	OTHER THERAPEUTIC SVC	0.00	1,465.20
CT SCAN	1,597,261.49	160,142.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	293,908.99	9,135.75	FEE SCHEDULE LAB	2,704,417.38	344,889.80
EKG/ECG	304,150.06	12,321.38	MRI SERVICES	467,143.31	16,578.56
IV THERAPY	827,195.28	152,493.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,491,789.23	683,680.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,438.35	8,603.49	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,403.73	3,715.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	470,020.50	2,579.53	AMBULANCE	0.00	0.00
GI SERVICES	85,018.50	19,762.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,283,644.43	11,727.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	165,709.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,003,728.79	576,009.40
RADIOLOGY THERAPEUTIC	602,864.87	370,763.52	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	748.82	698.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	365.51	2,582.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,456.51	187,511.26
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,844.34
OTHER IMAGING SERVICE	413,265.09	29,887.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,055.26	45,214.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	240,095.24	99,054.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	265,678.76	66,866.34			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	244,409.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	243,727.45	14,096.01			

TOTAL ANCILLARY	15,657,386.14	2,915,988.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,657,386.14	2,915,988.58

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 01/01/18 THROUGH 12/31/18
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	2018346086924	12/04/18 - 12/04/18	12/17/18	0.00	2,844.34	0.00	0.00	0.00
TOTAL				0.00	2,844.34	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	155,522.27	ADJUSTMENTS	0.00
COVERED CHARGES	125,704.20	CONTRACTUAL ALLOW	69,613.35
NON-COVERD CHARGES	29,818.07	TOTAL MEDICAID LIAB	56,090.85
		LESS: COB	56,025.00
		LESS: COPAYMENT	65.85
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,429.21	91.00	OTHER LAB	1,674.31	0.00
MED/SURG SUPPLY	1,547.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,481.50	763.93	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,221.23	7,274.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,488.64	2,921.02
EKG/ECG	6,267.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,822.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,393.40	16,417.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394.01	788.02	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,650.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,462.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,926.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,471.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,243.39	532.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,626.94	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	246.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	430.82	783.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,173.16	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	125,704.20	29,818.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	125,704.20	29,818.07

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	460,251.68	ADJUSTMENTS	5,238.40
COVERED CHARGES	439,030.87	CONTRACTUAL ALLOW	423,669.48
NON-COVERD CHARGES	21,220.81	TOTAL MEDICAID LIAB	15,361.39
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	14,971.39
		TOTAL NUMBER OF CLAIMS	248

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	983.46	91.00	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	16,649.28	2,076.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,444.93	5,580.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	88,384.04	7,571.49
EKG/ECG	2,961.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,137.18	1,509.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	711.54	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	256,445.85	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	8,236.80	512.24
RADIOLOGY THERAPEUTIC	1,990.00	282.68	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.84	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,983.65	3,596.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	439,030.87	21,220.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	439,030.87	21,220.81

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,405.79	ADJUSTMENTS	0.00
COVERED CHARGES	3,405.79	CONTRACTUAL ALLOW	2,375.39
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,030.40
		LESS: COB	1,027.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	438.11	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	2,957.75	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	9.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,405.79	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,405.79	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,621,394.22	ADJUSTMENTS	60,910.53
COVERED CHARGES	2,260,204.84	CONTRACTUAL ALLOW	1,938,581.50
NON-COVERD CHARGES	361,189.38	TOTAL MEDICAID LIAB	321,623.34
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	321,281.34

TOTAL NUMBER OF CLAIMS 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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,819.79	2,090.94	OTHER LAB	591.56	0.00
MED/SURG SUPPLY	69,641.86	744.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,802.25	1,376.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,042.45	2,926.87	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,128.44	FEE SCHEDULE LAB	32,412.41	3,418.86
EKG/ECG	5,429.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,283.78	18,937.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	551,855.93	39,378.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	570.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	112,716.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,829.79	502.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,583.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,226,453.14	52,796.41
RADIOLOGY THERAPEUTIC	139,850.14	50,644.98	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	86.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,767.14	182,685.44
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,422.79	606.02			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,144.36	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,989.16	866.36			

TOTAL ANCILLARY	2,260,204.84	361,189.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,260,204.84	361,189.38

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,784.08	ADJUSTMENTS	0.00
COVERED CHARGES	128,972.21	CONTRACTUAL ALLOW	29,442.21
NON-COVERD CHARGES	36,811.87	TOTAL MEDICAID LIAB	99,530.00
		LESS: COB	99,512.00
		LESS: COPAYMENT	18.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494.65	600.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,561.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	174.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,029.77	FEE SCHEDULE LAB	6,262.16	1,056.19
EKG/ECG	987.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	661.55	3,212.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	84,018.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,812.00	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	2,942.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,811.07	433.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	30,480.03
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.29	0.00			

TOTAL ANCILLARY	128,972.21	36,811.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	128,972.21	36,811.87

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,862,783.07	ADJUSTMENTS	178,277.50
COVERED CHARGES	1,825,273.07	CONTRACTUAL ALLOW	938,974.28
NON-COVERD CHARGES	37,510.00	TOTAL MEDICAID LIAB	886,298.79
		LESS: COB	7,841.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	878,457.39

TOTAL NUMBER OF ADMISSIONS 179

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	290	0	186,492.00	36,108.00
ROUTINE NURSERY	104	0	63,856.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	394	0	250,348.00	36,108.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	54	0	97,416.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	97,416.00	0.00
TOTAL ACCOMODATIONS	448	0	347,764.00	36,108.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,315.92	0.00	OTHER LAB	1,784.00	0.00
MED/SURG SUPPLY	153,745.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	278,244.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,198.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,674.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,103.00	0.00	MRI SERVICES	4,096.00	0.00
IV THERAPY	1,696.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	199,753.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	181,189.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,529.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,399.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,201.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,066.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,040.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,842.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,917.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,362.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,179.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,610.00	1,402.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	25,075.00	0.00			
CARDIOLOGY	14,574.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,434.00	0.00			

TOTAL ANCILLARY	1,477,509.07	1,402.00
TOTAL ACCOMODATIONS	347,764.00	36,108.00
TOTAL CHARGES	1,825,273.07	37,510.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,045,939.83	ADJUSTMENTS	143,247.44
COVERED CHARGES	2,782,453.91	CONTRACTUAL ALLOW	2,212,702.90
NON-COVERD CHARGES	263,485.92	TOTAL MEDICAID LIAB	569,751.01
		LESS: COB	685.91
		LESS: COPAYMENT	1,722.00
		REIMBURSEMENT	567,343.10
		ALL OTHER	476,406.38
		FEE SCHEDULE-LAB	85,015.98
		INJECTABLE DRUGS	5,920.74

TOTAL NUMBER OF CLAIMS 2,302

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,592.40	108.00	OTHER LAB	13,088.00	0.00
MED/SURG SUPPLY	163,359.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176,910.00	2,827.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	362,097.00	40,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,973.00	8,115.00	FEE SCHEDULE LAB	616,182.56	30,863.00
EKG/ECG	16,703.00	321.00	MRI SERVICES	14,740.00	6,201.00
IV THERAPY	29,164.00	1,632.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	311,153.62	84,067.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,394.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,603.00	12,899.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,536.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,312.33	6,528.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	478,359.00	3,244.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,218.00	6,044.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69,422.00	28,639.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,678.00	3,309.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	655.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,595.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,245.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,041.00	9,624.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,056.00	1,906.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,164.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	119,463.00	14,143.00			

TOTAL ANCILLARY	2,782,453.91	263,485.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,782,453.91	263,485.92

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,127.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,108.00	CONTRACTUAL ALLOW	-2,672.85
NON-COVERD CHARGES	7,019.00	TOTAL MEDICAID LIAB	8,780.85
		LESS: COB	8,780.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	793.00	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	892.00	56.00
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	6,902.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,158.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,594.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277.00	56.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,108.00	7,019.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,108.00	7,019.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,399.00	ADJUSTMENTS	804.76
COVERED CHARGES	58,894.00	CONTRACTUAL ALLOW	54,105.48
NON-COVERD CHARGES	2,505.00	TOTAL MEDICAID LIAB	4,788.52
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	4,677.52
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	671.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,839.00	741.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,704.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,644.00	1,677.00
EKG/ECG	321.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,256.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,243.00	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	1,601.00	87.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	58,894.00	2,505.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,894.00	2,505.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	882.00	ADJUSTMENTS	0.00
COVERED CHARGES	811.00	CONTRACTUAL ALLOW	178.94
NON-COVERD CHARGES	71.00	TOTAL MEDICAID LIAB	632.06
		LESS: COB	632.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	15.00	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	361.00	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	102.00	56.00
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	348.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	811.00	71.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	811.00	71.00

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

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,856.00	ADJUSTMENTS	5,545.23
COVERED CHARGES	136,157.33	CONTRACTUAL ALLOW	108,431.18
NON-COVERD CHARGES	24,698.67	TOTAL MEDICAID LIAB	27,726.15
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	27,699.15

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,549.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,791.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	291.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,278.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	254.00	FEE SCHEDULE LAB	4,224.00	1,563.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,518.00	136.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,976.33	13,838.67	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	4,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,483.00	7,492.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	55.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,440.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,516.00	1,360.00			

TOTAL ANCILLARY	136,157.33	24,698.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,157.33	24,698.67

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

GRADY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	599,340,814.32	ADJUSTMENTS	24,887,071.69
COVERED CHARGES	574,022,597.13	CONTRACTUAL ALLOW	460,883,256.68
NON-COVERD CHARGES	25,318,217.19	TOTAL MEDICAID LIAB	113,139,340.45
		LESS: COB	439,038.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	112,700,302.14

TOTAL NUMBER OF ADMISSIONS 7,180

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	34,155	0	59,343,910.00	7,788,886.00
ROUTINE NURSERY	5,126	0	11,774,373.00	1,506,447.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	273,558.53
TOTAL ROUTINE	39,281	0	71,118,283.00	9,568,892.03
SPECIAL CARE SERVICES				
CCU	694	0	2,320,426.00	30,402.00
ICU	14,509	0	60,461,813.00	807,416.00
NICU	383	0	2,197,188.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	401	0	2,356,352.00	0.00
BURN UNIT	926	0	6,808,449.00	620,704.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	16,913	0	74,144,228.00	1,458,522.00
TOTAL ACCOMODATIONS	56,194	0	145,262,511.00	11,027,414.03

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,659,896.33	547,898.00	OTHER LAB	2,412,103.00	9,769.00
MED/SURG SUPPLY	15,189,466.95	508,936.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,119,473.05	1,490,033.42	EDUCATION & TRAINING	1,513.00	0.00
RADIOLOGY-DIAGNOSTIC	12,794,788.50	61,891.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,400,667.00	749,420.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,260,469.65	774,915.09	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,528,496.00	22,540.00	MRI SERVICES	6,589,110.00	32,586.00
IV THERAPY	1,363,422.00	211,522.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	96,174,872.00	1,080,097.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,148,557.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,035,303.58	1,458,049.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,922,589.50	142,077.00	AMBULANCE	0.00	0.00
GI SERVICES	1,428,552.00	7,614.00	CAST ROOM	13,025.00	0.00
EMERGENCY ROOM	19,150,091.00	69,904.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,901,854.50	116,395.00	DRUG-SPECIFIC/HOME IV	0.00	307,512.43
LABORATORY PATHOLOGIC	2,235,866.00	35,684.00	INJECTABLE DRUGS	17,534,024.26	209,351.17
RADIOLOGY THERAPEUTIC	913,762.00	63,969.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,026,544.18	261,950.07	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,869,156.62	31,488.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,496,032.00	1,399,368.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,189.00	280,341.00	TRAUMA RESPONSE	0.00	267,290.00
PSYCHIATRIC SERVICES	7,667.00	0.00	IMPL DEV CHARGE PATIENTS	6,304,742.01	25,811.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,034,136.50	52,828.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,145,561.50	3,912,968.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,323,796.00	115,858.00			
AUDIOLOGY	415,252.00	495.00			
CARDIOLOGY	10,503,831.00	32,098.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,881,064.00	10,144.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,973,212.00	0.00			

TOTAL ANCILLARY	428,760,086.13	14,290,803.16
TOTAL ACCOMODATIONS	145,262,511.00	11,027,414.03
TOTAL CHARGES	574,022,597.13	25,318,217.19

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	976,635.95	ADJUSTMENTS	0.00
COVERED CHARGES	927,608.95	CONTRACTUAL ALLOW	436,982.49
NON-COVERD CHARGES	49,027.00	TOTAL MEDICAID LIAB	490,626.46
		LESS: COB	490,626.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	56	0	101,355.00	5,438.00
ROUTINE NURSERY	5	0	4,795.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	61	0	106,150.00	5,438.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	23,646.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	5	0	39,160.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	12	0	62,806.00	0.00
TOTAL ACCOMODATIONS	73	0	168,956.00	5,438.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,049.20	0.00	OTHER LAB	4,374.00	0.00
MED/SURG SUPPLY	15,609.32	348.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,999.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,001.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,685.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,904.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,410.00	0.00	MRI SERVICES	4,957.00	0.00
IV THERAPY	529.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	269,085.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,783.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,698.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,643.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,692.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,554.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,660.00	0.00	INJECTABLE DRUGS	20,292.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,520.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,654.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	701.00	TRAUMA RESPONSE	0.00	29,964.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,705.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,779.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,743.00	12,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	878.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,448.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	758,652.95	43,589.00
TOTAL ACCOMODATIONS	168,956.00	5,438.00
TOTAL CHARGES	927,608.95	49,027.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	180,190,700.30	ADJUSTMENTS	2,123,223.64
COVERED CHARGES	164,218,208.07	CONTRACTUAL ALLOW	138,743,939.88
NON-COVERD CHARGES	15,972,492.23	TOTAL MEDICAID LIAB	25,474,268.19
		LESS: COB	50,344.87
		LESS: COPAYMENT	161,807.75
		REIMBURSEMENT	25,262,115.57
		ALL OTHER	20,897,895.22
		FEE SCHEDULE-LAB	2,453,714.92
		INJECTABLE DRUGS	1,910,505.43

TOTAL NUMBER OF CLAIMS 79,497

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	701,329.08	191,708.91	OTHER LAB	2,554,803.00	58,845.00
MED/SURG SUPPLY	972,209.36	33,494.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	918.00	EDUCATION & TRAINING	0.00	23,963.00
RADIOLOGY-DIAGNOSTIC	8,104,215.00	170,657.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,725,552.00	1,990,840.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	648,599.00	829,998.02	FEE SCHEDULE LAB	43,720,903.00	1,999,583.00
EKG/ECG	3,114,270.00	89,528.00	MRI SERVICES	3,359,257.00	596,294.00
IV THERAPY	1,495,221.00	74,448.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,208,415.51	1,513,783.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	557,360.00	68,149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,898,646.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,601,345.07	403,168.93	CAST ROOM	11,776.00	0.00
EMERGENCY ROOM	31,241,254.00	994,892.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,050,291.00	0.00	DRUG-SPECIFIC/HOME IV	14,829.71	122,380.92
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,825,665.20	3,417,361.32
RADIOLOGY THERAPEUTIC	2,180,365.47	630,450.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	284,568.00	82,725.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	38,730.00	21,143.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,164.00	PATIENT CONVENIENCE	0.00	351.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,582,624.00	745,517.00	TRAUMA RESPONSE	0.00	50,878.00
PSYCHIATRIC SERVICES	575,144.00	159,266.04	IMPL DEV CHARGE PATIENTS	283,553.67	17,958.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,121,000.00	254,564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	956,101.00	368,554.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,529,843.00	457,449.00			
AUDIOLOGY	7,974.00	3,282.00			
CARDIOLOGY	2,600,065.00	474,064.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	216,732.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,035,567.00	119,114.00			

TOTAL ANCILLARY	164,218,208.07	15,972,492.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	164,218,208.07	15,972,492.23

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	511,596.30	ADJUSTMENTS	0.00
COVERED CHARGES	429,896.80	CONTRACTUAL ALLOW	212,976.12
NON-COVERD CHARGES	81,699.50	TOTAL MEDICAID LIAB	216,920.68
		LESS: COB	216,692.45
		LESS: COPAYMENT	228.23
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 186

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	994.76	143.34	OTHER LAB	3,026.00	388.00
MED/SURG SUPPLY	31.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	918.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,723.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,720.00	3,714.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	135,214.00	19,266.00
EKG/ECG	10,290.00	0.00	MRI SERVICES	14,429.00	0.00
IV THERAPY	5,857.00	1,179.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,732.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,857.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,896.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,205.00	9,500.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,755.04	6,626.16
RADIOLOGY THERAPEUTIC	1,805.00	10,026.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	9.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,317.00	2,774.00	TRAUMA RESPONSE	0.00	5,238.00
PSYCHIATRIC SERVICES	1,144.00	512.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,730.00	742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,817.00	16,768.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,372.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,378.00	0.00			

TOTAL ANCILLARY	429,896.80	81,699.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	429,896.80	81,699.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	910,038.93	ADJUSTMENTS	7,377.38
COVERED CHARGES	862,470.33	CONTRACTUAL ALLOW	839,130.27
NON-COVERD CHARGES	47,568.60	TOTAL MEDICAID LIAB	23,340.06
		LESS: COB	0.00
		LESS: COPAYMENT	1,023.00
		REIMBURSEMENT	22,317.06
		TOTAL NUMBER OF CLAIMS	381

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,358.88	1,107.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	637.00	46.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,156.00	3,185.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,416.00	19,664.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	143,980.00	6,233.00
EKG/ECG	17,640.00	980.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,179.00	150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	498,464.00	3,380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,718.45	11,411.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,875.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,315.00	1,412.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,574.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,749.00	0.00			
AUDIOLOGY	472.00	0.00			
CARDIOLOGY	17,856.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,080.00	0.00			

TOTAL ANCILLARY	862,470.33	47,568.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	862,470.33	47,568.60

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,614.86	ADJUSTMENTS	0.00
COVERED CHARGES	9,204.86	CONTRACTUAL ALLOW	6,422.80
NON-COVERD CHARGES	410.00	TOTAL MEDICAID LIAB	2,782.06
		LESS: COB	2,779.06
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139.86	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	3,101.00	410.00
EKG/ECG	980.00	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	4,984.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,204.86	410.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,204.86	410.00

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

GRADY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,512,876.77	ADJUSTMENTS	873,018.81
COVERED CHARGES	22,068,050.62	CONTRACTUAL ALLOW	18,174,932.56
NON-COVERD CHARGES	1,444,826.15	TOTAL MEDICAID LIAB	3,893,118.06
		LESS: COB	0.00
		LESS: COPAYMENT	1,893.00
		REIMBURSEMENT	3,891,225.06

TOTAL NUMBER OF CLAIMS 557

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,001.42	32,934.32	OTHER LAB	3,791.00	0.00
MED/SURG SUPPLY	323,562.50	6,089.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,072.00	48,268.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,221.00	13,789.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,883.00	FEE SCHEDULE LAB	463,033.00	13,030.00
EKG/ECG	4,410.00	5,880.00	MRI SERVICES	11,877.00	11,143.00
IV THERAPY	236,357.00	2,242.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,822,633.45	626,569.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,063.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,589,903.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,519.00	2,516.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,160,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,499,863.49	408,468.28
RADIOLOGY THERAPEUTIC	414,224.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,160.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	845.00	518.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	917,112.76	34,250.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,134.00	397.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,737.00	4,192.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,291.00	828.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	248,628.00	114,410.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	885,876.00	115,259.00			

TOTAL ANCILLARY	22,068,050.62	1,444,826.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,068,050.62	1,444,826.15

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,717.56	ADJUSTMENTS	0.00
COVERED CHARGES	20,717.56	CONTRACTUAL ALLOW	12,385.42
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,332.14
		LESS: COB	8,329.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	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	19,789.56	0.00
RADIOLOGY THERAPEUTIC	906.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,717.56	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,717.56	0.00

** END OF REPORT **

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,013,095.24	ADJUSTMENTS	20,477.56
COVERED CHARGES	2,001,165.53	CONTRACTUAL ALLOW	1,004,305.42
NON-COVERD CHARGES	11,929.71	TOTAL MEDICAID LIAB	996,860.11
		LESS: COB	29,645.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	967,215.02

TOTAL NUMBER OF ADMISSIONS 226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	391	0	179,860.00	0.00
ROUTINE NURSERY	140	0	42,100.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	460.00
TOTAL ROUTINE	531	0	221,960.00	460.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	62	0	68,200.00	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	62	0	68,200.00	0.00
TOTAL ACCOMODATIONS	593	0	290,160.00	460.00

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,198.86	0.00	OTHER LAB	2,286.00	0.00
MED/SURG SUPPLY	153,927.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	225,461.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,970.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,035.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,170.00	0.00	MRI SERVICES	4,098.75	0.00
IV THERAPY	273,234.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,776.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	219,752.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,531.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,061.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	84,586.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,615.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	566.00	0.00	INJECTABLE DRUGS	43,326.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,422.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	135.21
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,575.50	274.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,582.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,003.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,288.50	10,560.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,381.50	500.00			
AUDIOLOGY	15,019.75	0.00			
CARDIOLOGY	12,148.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,881.75	0.00			

TOTAL ANCILLARY	1,711,005.53	11,469.71
TOTAL ACCOMODATIONS	290,160.00	460.00
TOTAL CHARGES	2,001,165.53	11,929.71

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,015.15	ADJUSTMENTS	0.00
COVERED CHARGES	25,955.01	CONTRACTUAL ALLOW	7,832.62
NON-COVERD CHARGES	1,060.14	TOTAL MEDICAID LIAB	18,122.39
		LESS: COB	18,122.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	2,760.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	2,760.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,760.00	0.00

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,818.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,798.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,099.25	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	4,374.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,258.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,166.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,118.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,454.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	185.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	4.14
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	329.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	592.50	1,056.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,195.01	1,060.14
TOTAL ACCOMODATIONS	2,760.00	0.00
TOTAL CHARGES	25,955.01	1,060.14

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,978,757.42	ADJUSTMENTS	145,819.61
COVERED CHARGES	2,872,061.69	CONTRACTUAL ALLOW	2,198,346.28
NON-COVERD CHARGES	106,695.73	TOTAL MEDICAID LIAB	673,715.41
		LESS: COB	1,951.74
		LESS: COPAYMENT	1,418.41
		REIMBURSEMENT	670,345.26
		ALL OTHER	582,829.78
		FEE SCHEDULE-LAB	77,313.78
		INJECTABLE DRUGS	10,201.70

TOTAL NUMBER OF CLAIMS 1,958

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,032.43	0.00	OTHER LAB	78,908.25	0.00
MED/SURG SUPPLY	99,053.26	281.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,752.00	2,041.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	551,116.25	23,022.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,551.50	3,967.01	FEE SCHEDULE LAB	529,746.50	5,889.75
EKG/ECG	43,618.00	3,164.00	MRI SERVICES	61,934.75	0.00
IV THERAPY	25,805.25	16,594.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	76,676.00	8,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,594.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,144.25	1,450.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,588.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	916,683.50	21,064.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,116.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,945.63	4,267.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,884.25	678.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	789.50	567.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	13.95
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,188.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,362.12	1,050.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,772.00	3,432.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,033.75	1,584.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,624.75	2,939.00			
AUDIOLOGY	2,469.00	0.00			
CARDIOLOGY	14,278.50	1,070.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,580.75	2,025.75			

TOTAL ANCILLARY	2,872,061.69	106,695.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,872,061.69	106,695.73

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,419.44	ADJUSTMENTS	0.00
COVERED CHARGES	52,704.44	CONTRACTUAL ALLOW	31,524.47
NON-COVERD CHARGES	4,715.00	TOTAL MEDICAID LIAB	21,179.97
		LESS: COB	21,149.97
		LESS: COPAYMENT	30.00
		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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,427.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,963.45	418.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,493.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,524.25	1,967.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,362.75	FEE SCHEDULE LAB	6,612.00	68.00
EKG/ECG	565.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	136.75	159.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,085.75	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	2,659.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,629.50	355.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,914.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	171.13	12.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	84.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,058.50	287.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,732.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	731.50	0.00			

TOTAL ANCILLARY	52,704.44	4,715.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,704.44	4,715.00

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,272.22	ADJUSTMENTS	0.00
COVERED CHARGES	23,227.72	CONTRACTUAL ALLOW	20,654.48
NON-COVERD CHARGES	44.50	TOTAL MEDICAID LIAB	2,573.24
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	2,519.24
		TOTAL NUMBER OF CLAIMS	46

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220.66	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	852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,505.00	32.00
EKG/ECG	339.00	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	18,063.50	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	297.56	12.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,227.72	44.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,227.72	44.50

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,156.49	ADJUSTMENTS	0.00
COVERED CHARGES	11,964.49	CONTRACTUAL ALLOW	8,814.12
NON-COVERD CHARGES	192.00	TOTAL MEDICAID LIAB	3,150.37
		LESS: COB	3,150.37
		LESS: COPAYMENT	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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	412.74	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	126.00	126.00	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	3,360.50	66.00
EKG/ECG	113.00	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	7,375.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,964.49	192.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,964.49	192.00

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,288.86	ADJUSTMENTS	5,566.29
COVERED CHARGES	19,094.86	CONTRACTUAL ALLOW	13,528.57
NON-COVERD CHARGES	194.00	TOTAL MEDICAID LIAB	5,566.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,566.29

TOTAL NUMBER OF CLAIMS 1

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.38	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	252.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,435.00	0.00
EKG/ECG	113.00	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	5,011.75	194.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,773.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,094.86	194.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,094.86	194.00

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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	143,659,782.87	ADJUSTMENTS	5,025,835.90
COVERED CHARGES	136,764,677.09	CONTRACTUAL ALLOW	107,265,723.62
NON-COVERD CHARGES	6,895,105.78	TOTAL MEDICAID LIAB	29,498,953.47
		LESS: COB	149,170.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,349,783.37

TOTAL NUMBER OF ADMISSIONS 3,055

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,297	0	13,339,498.00	4,195,747.00
ROUTINE NURSERY	2,300	0	2,552,473.00	113,947.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14,597	0	15,891,971.00	4,309,694.00
SPECIAL CARE SERVICES				
CCU	303	0	601,708.00	0.00
ICU	2,505	0	5,923,152.00	0.00
NICU	18	0	38,160.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,826	0	6,563,020.00	0.00
TOTAL ACCOMODATIONS	17,423	0	22,454,991.00	4,309,694.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,573,166.81	277,639.00	OTHER LAB	851,085.00	1,353.00
MED/SURG SUPPLY	10,888,946.33	103,799.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,706,616.75	115,711.00	EDUCATION & TRAINING	933.00	0.00
RADIOLOGY-DIAGNOSTIC	1,153,831.00	2,785.00	OTHER THERAPEUTIC SVC	0.00	886.00
CT SCAN	7,057,879.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	690,812.00	5,658.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	714,585.00	1,861.00	MRI SERVICES	1,294,942.00	0.00
IV THERAPY	2,158,614.00	43,103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,681,983.00	55,630.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,020,701.00	9,904.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,419,327.01	22,536.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,615,390.00	11,677.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,132,452.00	3,998.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,580,012.00	19,780.00	DRUG-SPECIFIC/HOME IV	0.00	72,406.00
LABORATORY PATHOLOGIC	513,195.82	635.28	INJECTABLE DRUGS	80,255.00	0.00
RADIOLOGY THERAPEUTIC	221,674.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	276,674.00	936.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	337,185.00	2,337.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	879,330.00	357,655.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66,843.00	13,338.00	TRAUMA RESPONSE	0.00	135,054.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,017,981.07	8,619.58
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,259.00
OTHER IMAGING SERVICE	758,762.70	1,448.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	795,667.00	954,513.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	484,048.00	89,213.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,965,359.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	171,928.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,199,507.00	267,677.00			

TOTAL ANCILLARY	114,309,686.09	2,585,411.78
TOTAL ACCOMODATIONS	22,454,991.00	4,309,694.00
TOTAL CHARGES	136,764,677.09	6,895,105.78

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 10/01/17 THROUGH 09/30/18
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	2218303006918	02/15/18 - 03/22/18	11/05/18	0.00	5,259.00	0.00	0.00	0.00
TOTAL				0.00	5,259.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,561,414.24	ADJUSTMENTS	0.00
COVERED CHARGES	2,393,705.24	CONTRACTUAL ALLOW	1,092,641.56
NON-COVERD CHARGES	167,709.00	TOTAL MEDICAID LIAB	1,301,063.68
		LESS: COB	1,301,063.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	257	0	286,296.00	139,563.00
ROUTINE NURSERY	171	0	254,586.00	14,439.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	428	0	540,882.00	154,002.00
SPECIAL CARE SERVICES				
CCU	17	0	36,105.00	0.00
ICU	8	0	15,270.00	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	25	0	51,375.00	0.00
TOTAL ACCOMODATIONS	453	0	592,257.00	154,002.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,315.00	0.00	OTHER LAB	30,135.00	0.00
MED/SURG SUPPLY	235,813.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	192,063.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,624.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,645.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,048.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,497.00	0.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	225,913.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	198,141.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	91,105.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,201.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	165,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,852.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	709.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,426.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,622.00	1,488.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,693.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,357.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,168.00	3,682.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,143.00	1,426.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,628.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,464.00	7,061.00			

TOTAL ANCILLARY	1,801,448.24	13,707.00
TOTAL ACCOMODATIONS	592,257.00	154,002.00
TOTAL CHARGES	2,393,705.24	167,709.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,653,080.90	ADJUSTMENTS	937,151.97
COVERED CHARGES	41,034,312.15	CONTRACTUAL ALLOW	35,092,278.22
NON-COVERD CHARGES	9,618,768.75	TOTAL MEDICAID LIAB	5,942,033.93
		LESS: COB	2,175.41
		LESS: COPAYMENT	12,662.27
		REIMBURSEMENT	5,927,196.25
		ALL OTHER	4,967,976.58
		FEE SCHEDULE-LAB	506,831.43
		INJECTABLE DRUGS	452,388.24

TOTAL NUMBER OF CLAIMS 11,317

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,996.80	522,047.39	OTHER LAB	538,002.00	4,600.00
MED/SURG SUPPLY	895,162.18	339,215.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,095,326.00	120,541.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,227,768.00	735,405.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	210,280.00	33,080.04	FEE SCHEDULE LAB	6,421,803.62	699,076.90
EKG/ECG	643,389.00	10,477.00	MRI SERVICES	1,322,096.00	143,994.00
IV THERAPY	2,528,570.00	336,864.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,472,403.21	426,508.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,655.00	10,465.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,233.00	37,422.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,056,518.00	1,701.00	AMBULANCE	0.00	0.00
GI SERVICES	17,918.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,540,066.00	12,246.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,631,516.00	82,283.00	DRUG-SPECIFIC/HOME IV	12,570.00	5,784.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,654,951.00	2,996,041.82
RADIOLOGY THERAPEUTIC	1,512,504.00	640,205.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,207.00	30,205.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,741.00	11,202.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,260.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,316.00	13,662.00	TRAUMA RESPONSE	0.00	38,672.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,638.34	1,090,272.42
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	163.00	0.00
OTHER IMAGING SERVICE	1,671,788.40	89,098.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,734.00	92,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	932,875.00	434,108.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,516,943.00	487,535.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	510,679.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,077,499.00	152,747.00			

TOTAL ANCILLARY	41,034,312.15	9,618,768.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,034,312.15	9,618,768.75

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
626	9818063000904	10/20/17 - 10/20/17	03/12/18	163.00	0.00	0.00	0.00	0.00
-1	2018144059126	05/08/18 - 01/01/00	06/04/18	0.00	0.00	0.00	0.00	0.00
-1	2018144059430	05/17/18 - 01/01/00	06/11/18	0.00	0.00	0.00	0.00	0.00
-1	2018144059430	05/17/18 - 01/01/00	06/11/18	0.00	0.00	0.00	0.00	0.00
TOTAL				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 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	749,049.45	ADJUSTMENTS	0.00
COVERED CHARGES	595,402.19	CONTRACTUAL ALLOW	312,375.12
NON-COVERD CHARGES	153,647.26	TOTAL MEDICAID LIAB	283,027.07
		LESS: COB	282,862.29
		LESS: COPAYMENT	164.78
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 165

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,226.00	13,754.00	OTHER LAB	16,304.00	0.00
MED/SURG SUPPLY	21,259.30	1,016.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,319.00	2,714.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,139.00	10,569.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	553.00	FEE SCHEDULE LAB	96,899.60	15,251.00
EKG/ECG	9,559.00	0.00	MRI SERVICES	24,014.00	10,954.00
IV THERAPY	52,768.00	5,131.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	25,630.50	30,700.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,149.00	1,224.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	311.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,999.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,811.00	558.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,722.00	1,707.00	DRUG-SPECIFIC/HOME IV	2,836.00	1,928.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,824.00	8,682.00
RADIOLOGY THERAPEUTIC	18,806.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	512.00	TRAUMA RESPONSE	0.00	4,618.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,719.79	28,738.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,592.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,356.00	3,682.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,478.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,261.00	2,809.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,715.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,815.00	1,707.00			

TOTAL ANCILLARY	595,402.19	153,647.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	595,402.19	153,647.26

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	611,564.40	ADJUSTMENTS	5,613.03
COVERED CHARGES	587,720.40	CONTRACTUAL ALLOW	561,048.04
NON-COVERD CHARGES	23,844.00	TOTAL MEDICAID LIAB	26,672.36
		LESS: COB	0.00
		LESS: COPAYMENT	507.00
		REIMBURSEMENT	26,165.36
		TOTAL NUMBER OF CLAIMS	460

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.00	3,704.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,244.00	740.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,958.40	7,724.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,059.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,190.00	8,380.00
EKG/ECG	3,366.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,626.00	922.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,373.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,543.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,847.00	2,374.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	6.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,798.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,356.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	225.00	0.00			

TOTAL ANCILLARY	587,720.40	23,844.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	587,720.40	23,844.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,548.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,851.00	CONTRACTUAL ALLOW	8,349.22
NON-COVERD CHARGES	697.00	TOTAL MEDICAID LIAB	6,501.78
		LESS: COB	6,492.78
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	221.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	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	5,052.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,167.00	72.00
EKG/ECG	306.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,378.00	304.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,445.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,851.00	697.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,851.00	697.00

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 IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,967,995.37	ADJUSTMENTS	254,182.80
COVERED CHARGES	5,840,144.30	CONTRACTUAL ALLOW	4,982,138.00
NON-COVERD CHARGES	1,127,851.07	TOTAL MEDICAID LIAB	858,006.30
		LESS: COB	0.00
		LESS: COPAYMENT	750.74
		REIMBURSEMENT	857,255.56
		TOTAL NUMBER OF CLAIMS	155

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

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,288.00	97,032.00	OTHER LAB	1,211.00	0.00
MED/SURG SUPPLY	372,150.99	139,832.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	121.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,932.00	15,432.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,138.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,110.00	FEE SCHEDULE LAB	86,244.50	18,294.00
EKG/ECG	11,934.00	306.00	MRI SERVICES	4,267.00	0.00
IV THERAPY	130,546.00	17,084.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,050,007.40	111,881.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,636.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	350,414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,108.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	553,460.00	10,048.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,821,057.00	219,871.00
RADIOLOGY THERAPEUTIC	171,134.00	34,050.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,252.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	85,410.41	433,411.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,630.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	678.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,124.00	869.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	84,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,532.00	24,143.00			

TOTAL ANCILLARY	5,840,144.30	1,127,851.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,840,144.30	1,127,851.07

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,869.05	ADJUSTMENTS	0.00
COVERED CHARGES	44,150.05	CONTRACTUAL ALLOW	21,326.14
NON-COVERD CHARGES	2,719.00	TOTAL MEDICAID LIAB	22,823.91
		LESS: COB	22,820.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.00	2,443.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,359.45	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	947.60	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	21,839.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,787.00	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	8,405.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	497.00	276.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	44,150.05	2,719.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,150.05	2,719.00

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,391,395.98	ADJUSTMENTS	1,099,251.01
COVERED CHARGES	22,901,864.95	CONTRACTUAL ALLOW	18,085,453.63
NON-COVERD CHARGES	489,531.03	TOTAL MEDICAID LIAB	4,816,411.32
		LESS: COB	39,460.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,776,950.73

TOTAL NUMBER OF ADMISSIONS 389

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,337	0	1,487,904.00	181,436.00
ROUTINE NURSERY	217	0	245,279.00	17,198.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,554	0	1,733,183.00	198,634.00
SPECIAL CARE SERVICES				
CCU	62	0	141,780.00	0.00
ICU	498	0	1,248,150.00	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	560	0	1,389,930.00	0.00
TOTAL ACCOMODATIONS	2,114	0	3,123,113.00	198,634.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,260,116.11	7,228.00	OTHER LAB	100,990.00	0.00
MED/SURG SUPPLY	1,859,595.18	16,140.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,906,608.80	7,283.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167,205.00	0.00	OTHER THERAPEUTIC SVC	23,825.00	0.00
CT SCAN	1,134,330.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	145,332.00	160.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	125,510.00	0.00	MRI SERVICES	282,717.00	0.00
IV THERAPY	441,310.00	1,208.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,542,644.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	69,978.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,605,750.00	1,487.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	534,755.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	472,133.00	1,325.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	410,849.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,418.00
LABORATORY PATHOLOGIC	81,130.20	0.00	INJECTABLE DRUGS	32,539.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	53,938.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,278.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	192,720.00	59,532.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,407.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	791,443.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,974.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,156.00	122,846.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,052.00	12,421.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	813,871.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,846.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	326,749.00	59,849.00			

TOTAL ANCILLARY	19,778,751.95	290,897.03
TOTAL ACCOMODATIONS	3,123,113.00	198,634.00
TOTAL CHARGES	22,901,864.95	489,531.03

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	425,160.09	ADJUSTMENTS	0.00
COVERED CHARGES	404,775.09	CONTRACTUAL ALLOW	179,073.52
NON-COVERD CHARGES	20,385.00	TOTAL MEDICAID LIAB	225,701.57
		LESS: COB	225,701.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	43,226.00	16,483.00
ROUTINE NURSERY	12	0	14,097.00	1,244.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	51	0	57,323.00	17,727.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	5,130.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	5,130.00	0.00
TOTAL ACCOMODATIONS	53	0	62,453.00	17,727.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,019.00	0.00	OTHER LAB	6,900.00	0.00
MED/SURG SUPPLY	32,593.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,907.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,472.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,255.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	666.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	3,390.00	0.00
IV THERAPY	5,541.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,748.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,240.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,015.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,672.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,818.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,463.20	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	226.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,239.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,809.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,707.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,521.00	2,658.00			

TOTAL ANCILLARY	342,322.09	2,658.00
TOTAL ACCOMODATIONS	62,453.00	17,727.00
TOTAL CHARGES	404,775.09	20,385.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,044,683.04	ADJUSTMENTS	329,299.12
COVERED CHARGES	10,989,330.99	CONTRACTUAL ALLOW	9,450,025.33
NON-COVERD CHARGES	2,055,352.05	TOTAL MEDICAID LIAB	1,539,305.66
		LESS: COB	1,872.69
		LESS: COPAYMENT	2,947.98
		REIMBURSEMENT	1,534,484.99
		ALL OTHER	1,389,785.48
		FEE SCHEDULE-LAB	106,677.48
		INJECTABLE DRUGS	38,022.03

TOTAL NUMBER OF CLAIMS 2,519

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,807.48	142,579.00	OTHER LAB	187,055.00	954.00
MED/SURG SUPPLY	292,620.54	103,569.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	363,414.00	36,532.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,751,978.00	152,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,445.00	2,145.02	FEE SCHEDULE LAB	1,446,366.50	194,236.30
EKG/ECG	189,094.00	2,448.00	MRI SERVICES	392,852.00	33,516.00
IV THERAPY	743,001.00	92,012.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,151,071.33	223,181.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,142.00	1,623.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,780.00	3,704.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	297,080.00	972.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,722,882.00	2,835.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	501,724.00	15,619.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	608,256.40	213,615.00
RADIOLOGY THERAPEUTIC	262,571.00	309,752.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	389.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	337.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,921.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,457.74	235,577.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	230,945.00	22,511.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,372.00	16,569.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	165,122.00	83,638.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	330,912.00	143,299.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	77,426.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	127,956.00	19,617.00			

TOTAL ANCILLARY	10,989,330.99	2,055,352.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,989,330.99	2,055,352.05

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,381.52	ADJUSTMENTS	0.00
COVERED CHARGES	202,890.52	CONTRACTUAL ALLOW	93,937.25
NON-COVERD CHARGES	49,491.00	TOTAL MEDICAID LIAB	108,953.27
		LESS: COB	108,931.76
		LESS: COPAYMENT	21.51
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,188.00	6,872.00	OTHER LAB	4,277.00	0.00
MED/SURG SUPPLY	4,162.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,583.00	2,610.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,018.00	7,307.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,407.00	3,787.00
EKG/ECG	1,530.00	0.00	MRI SERVICES	9,593.00	3,093.00
IV THERAPY	17,549.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,423.00	15,294.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	306.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,313.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,387.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,414.00	3,281.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,252.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,628.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,809.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	202,890.52	49,491.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	202,890.52	49,491.00

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 INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	595,574.00	ADJUSTMENTS	2,870.52
COVERED CHARGES	544,636.00	CONTRACTUAL ALLOW	531,691.40
NON-COVERD CHARGES	50,938.00	TOTAL MEDICAID LIAB	12,944.60
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	12,611.60

TOTAL NUMBER OF CLAIMS 223

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252.00	8,848.00	OTHER LAB	4,059.00	0.00
MED/SURG SUPPLY	104.00	185.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,910.00	6,155.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,758.00	14,614.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	90,923.00	9,199.00
EKG/ECG	9,792.00	0.00	MRI SERVICES	3,040.00	3,018.00
IV THERAPY	41,494.00	3,486.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,280.00	558.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,307.00	3,430.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,039.00	1,445.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	544,636.00	50,938.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	544,636.00	50,938.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,169.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,795.00	CONTRACTUAL ALLOW	17,665.14
NON-COVERD CHARGES	6,374.00	TOTAL MEDICAID LIAB	8,129.86
		LESS: COB	8,120.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,105.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	463.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,375.00	499.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,052.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,262.00	72.00
EKG/ECG	0.00	0.00	MRI SERVICES	5,277.00	0.00
IV THERAPY	5,591.00	4,256.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,204.00	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	571.00	442.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,795.00	6,374.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,795.00	6,374.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,434,322.31	ADJUSTMENTS	62,375.88
COVERED CHARGES	1,218,883.33	CONTRACTUAL ALLOW	1,067,908.64
NON-COVERD CHARGES	215,438.98	TOTAL MEDICAID LIAB	150,974.69
		LESS: COB	0.00
		LESS: COPAYMENT	109.51
		REIMBURSEMENT	150,865.18

TOTAL NUMBER OF CLAIMS 29

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,532.00	21,546.00	OTHER LAB	1,211.00	0.00
MED/SURG SUPPLY	209,491.44	11,313.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,721.00	4,345.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,558.00	6,059.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,293.50	7,803.40
EKG/ECG	5,814.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	40,148.00	6,384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	467,060.50	7,026.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	154,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,191.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,419.00	7,082.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,505.00	20,961.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,906.89	107,889.82
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,445.00	1,239.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	762.00	1,841.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,809.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,200.00	11,949.00			

TOTAL ANCILLARY	1,218,883.33	215,438.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,218,883.33	215,438.98

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,946,501.02	ADJUSTMENTS	701,592.36
COVERED CHARGES	35,538,022.00	CONTRACTUAL ALLOW	27,775,288.38
NON-COVERD CHARGES	408,479.02	TOTAL MEDICAID LIAB	7,762,733.62
		LESS: COB	60,632.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,702,100.67

TOTAL NUMBER OF ADMISSIONS 1,226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,219	0	4,292,990.00	69,192.00
ROUTINE NURSERY	814	0	1,233,770.00	121,680.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,033	0	5,526,760.00	190,872.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	480	0	1,562,930.00	0.00
NICU	291	0	1,505,362.50	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	771	0	3,068,292.50	0.00
TOTAL ACCOMODATIONS	4,804	0	8,595,052.50	190,872.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,241,317.31	1,512.15	OTHER LAB	128,434.00	0.00
MED/SURG SUPPLY	1,518,749.51	18,720.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,422,699.03	12,168.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	674,764.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,458,055.00	26,432.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	157,663.56	2,040.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	334,734.00	0.00	MRI SERVICES	566,978.00	0.00
IV THERAPY	466,547.00	3,875.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,060,288.50	12,624.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,603,871.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,951,280.11	5,013.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	156,482.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,213,916.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	277,757.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	105,102.20	0.00	INJECTABLE DRUGS	390,246.46	0.00
RADIOLOGY THERAPEUTIC	36,789.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,697.33	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,988.12	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	85,695.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,298.00	822.00	TRAUMA RESPONSE	0.00	28,112.00
PSYCHIATRIC SERVICES	281,103.00	3,535.00	IMPL DEV CHARGE PATIENTS	663,759.37	0.00
LITHOTRIPSY	28,504.00	0.00	NO CC/INVALID REV CODE	0.00	64,180.00
OTHER IMAGING SERVICE	230,857.00	0.00			
BLOOD	83,097.00	0.00			
BLOOD STORAGE & PRO.	115,525.50	38,216.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	202,249.00	0.00			
AUDIOLOGY	140,999.00	0.00			
CARDIOLOGY	1,186,704.50	357.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,186.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,633.00	0.00			

TOTAL ANCILLARY	26,942,969.50	217,607.02
TOTAL ACCOMODATIONS	8,595,052.50	190,872.00
TOTAL CHARGES	35,538,022.00	408,479.02

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 10/01/17 THROUGH 09/30/18
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	2017334000407	11/21/17 - 11/23/17	12/04/17	0.00	6,269.00	0.00	0.00	0.00
614	2018046066442	02/01/18 - 02/09/18	02/19/18	0.00	2,064.00	0.00	0.00	0.00
614	2018058000526	02/09/18 - 02/17/18	03/05/18	0.00	15,981.00	0.00	0.00	0.00
614	2018082076363	02/20/18 - 02/28/18	03/26/18	0.00	6,027.00	0.00	0.00	0.00
614	2218099008156	01/20/18 - 01/25/18	04/16/18	0.00	6,269.00	0.00	0.00	0.00
614	2018117018630	04/10/18 - 04/18/18	04/30/18	0.00	6,894.00	0.00	0.00	0.00
614	2018138020620	01/26/18 - 02/05/18	05/21/18	0.00	12,585.00	0.00	0.00	0.00
614	2018159012202	05/23/18 - 05/24/18	06/11/18	0.00	2,064.00	0.00	0.00	0.00
614	2019060000486	06/11/18 - 06/13/18	03/04/19	0.00	6,027.00	0.00	1,314.64	0.00
TOTAL				0.00	64,180.00	0.00	1,314.64	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	322,656.45	ADJUSTMENTS	0.00
COVERED CHARGES	312,916.45	CONTRACTUAL ALLOW	138,656.50
NON-COVERD CHARGES	9,740.00	TOTAL MEDICAID LIAB	174,259.95
		LESS: COB	174,259.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	54	0	72,022.00	2,846.00
ROUTINE NURSERY	14	0	13,360.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	68	0	85,382.00	2,846.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1	0	4,435.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,435.00	0.00
TOTAL ACCOMODATIONS	69	0	89,817.00	2,846.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,525.08	0.00	OTHER LAB	3,909.00	0.00
MED/SURG SUPPLY	9,050.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,597.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,354.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,248.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,291.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,184.00	0.00	MRI SERVICES	6,069.00	0.00
IV THERAPY	3,306.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,452.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,073.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,518.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,328.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,016.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	145.00	0.00	INJECTABLE DRUGS	972.70	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	297.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	15,574.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,894.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,688.00	0.00			
CARDIOLOGY	5,502.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	223,099.45	6,894.00
TOTAL ACCOMODATIONS	89,817.00	2,846.00
TOTAL CHARGES	312,916.45	9,740.00

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 10/01/17 THROUGH 09/30/18
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	2018229041948	03/20/18 - 03/23/18	08/20/18	0.00	6,894.00	0.00	23,112.11	0.00
TOTAL				0.00	6,894.00	0.00	23,112.11	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,997,376.08	ADJUSTMENTS	867,133.86
COVERED CHARGES	28,624,619.67	CONTRACTUAL ALLOW	24,783,748.26
NON-COVERD CHARGES	1,372,756.41	TOTAL MEDICAID LIAB	3,840,871.41
		LESS: COB	1,790.97
		LESS: COPAYMENT	7,936.83
		REIMBURSEMENT	3,831,143.61
		ALL OTHER	3,134,570.04
		FEE SCHEDULE-LAB	383,082.11
		INJECTABLE DRUGS	313,491.46

TOTAL NUMBER OF CLAIMS 8,776

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	553,797.56	2,539.40	OTHER LAB	732,397.00	1,915.00
MED/SURG SUPPLY	781,037.37	5,181.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	10,546.00	268.00
RADIOLOGY-DIAGNOSTIC	1,432,002.00	28,527.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,213,375.00	184,253.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,103.00	16,067.12	FEE SCHEDULE LAB	6,827,152.46	279,491.28
EKG/ECG	510,288.00	5,652.00	MRI SERVICES	998,852.00	67,548.00
IV THERAPY	1,524,662.00	170,919.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,567,230.87	118,483.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,988.00	1,004.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	359,175.00	51,231.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	172,112.00	1,656.00	AMBULANCE	0.00	0.00
GI SERVICES	8,273.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,710,990.50	2,837.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	150,112.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,182,775.55	55,325.05
RADIOLOGY THERAPEUTIC	498,013.00	26,906.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,129.00	5,081.24	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,980.00	1,719.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,038.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,835.00	1,480.00	TRAUMA RESPONSE	0.00	96,850.00
PSYCHIATRIC SERVICES	1,399.00	14,070.00	IMPL DEV CHARGE PATIENTS	72,565.36	0.00
LITHOTRIPSY	109,814.00	0.00	NO CC/INVALID REV CODE	0.00	4,280.00
OTHER IMAGING SERVICE	744,331.00	122,679.00			
BLOOD	135,818.00	1,612.00			
BLOOD STORAGE & PRO.	82,844.00	3,836.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	465,073.00	28,007.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	849,719.00	46,129.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	141,714.00	3,088.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	680,516.00	20,083.00			

TOTAL ANCILLARY	28,624,619.67	1,372,756.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,624,619.67	1,372,756.41

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 10/01/17 THROUGH 09/30/18
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	5918319004697	08/31/18 - 08/31/18	11/19/18	0.00	2,174.00	0.00	0.00	0.00
615	5918319004697	08/31/18 - 08/31/18	11/19/18	0.00	2,106.00	0.00	0.00	0.00
TOTAL				0.00	4,280.00	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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	658,139.45	ADJUSTMENTS	0.00
COVERED CHARGES	572,194.95	CONTRACTUAL ALLOW	274,292.00
NON-COVERD CHARGES	85,944.50	TOTAL MEDICAID LIAB	297,902.95
		LESS: COB	297,762.49
		LESS: COPAYMENT	140.46
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 153

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,328.88	0.00	OTHER LAB	6,118.00	0.00
MED/SURG SUPPLY	43,321.59	238.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	308.00	0.00
RADIOLOGY-DIAGNOSTIC	28,865.00	1,287.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,626.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	475.00	0.00	FEE SCHEDULE LAB	98,118.57	5,413.50
EKG/ECG	5,990.00	0.00	MRI SERVICES	24,445.00	0.00
IV THERAPY	25,352.00	3,286.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	68,029.00	42,587.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,450.00	1,562.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,397.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,606.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,199.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,722.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,339.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	278.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,801.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,172.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,284.00	21,620.00			
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	15,265.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,634.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,070.00	7,662.00			

TOTAL ANCILLARY	572,194.95	85,944.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	572,194.95	85,944.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	220,577.67	ADJUSTMENTS	1,856.20
COVERED CHARGES	216,054.67	CONTRACTUAL ALLOW	205,817.56
NON-COVERD CHARGES	4,523.00	TOTAL MEDICAID LIAB	10,237.11
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	9,964.11

TOTAL NUMBER OF CLAIMS 174

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,996.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,308.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,009.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,760.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	241.00	0.00	FEE SCHEDULE LAB	44,818.00	2,234.00
EKG/ECG	5,034.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,204.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	135,057.00	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	164.30	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	94.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,528.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	216,054.67	4,523.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	216,054.67	4,523.00

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,590.34	ADJUSTMENTS	0.00
COVERED CHARGES	24,072.34	CONTRACTUAL ALLOW	12,709.90
NON-COVERD CHARGES	518.00	TOTAL MEDICAID LIAB	11,362.44
		LESS: COB	11,359.44
		LESS: COPAYMENT	3.00
		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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	282.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,118.00	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	4,577.00	518.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	778.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,096.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,091.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,072.34	518.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,072.34	518.00

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,372,969.58	ADJUSTMENTS	138,399.75
COVERED CHARGES	5,163,696.55	CONTRACTUAL ALLOW	4,686,806.77
NON-COVERD CHARGES	209,273.03	TOTAL MEDICAID LIAB	476,889.78
		LESS: COB	0.00
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	476,220.78
		TOTAL NUMBER OF CLAIMS	86

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,031.96	7,554.45	OTHER LAB	5,440.00	0.00
MED/SURG SUPPLY	127,224.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,640.00	26,440.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,067.00	7,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278.00	475.00	FEE SCHEDULE LAB	125,618.68	11,695.12
EKG/ECG	10,944.00	1,174.00	MRI SERVICES	33,051.00	2,174.00
IV THERAPY	142,950.00	4,710.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	732,650.00	17,031.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,834.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,247.00	563.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,555.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,687,516.03	48,953.46
RADIOLOGY THERAPEUTIC	356,974.00	8,896.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	495.00	495.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	203.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	250,493.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	562.00	0.00			
BLOOD	19,480.00	0.00			
BLOOD STORAGE & PRO.	5,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,001.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	479,555.00	71,054.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,088.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,488.00	235.00			

TOTAL ANCILLARY	5,163,696.55	209,273.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,163,696.55	209,273.03

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	436,441.71	ADJUSTMENTS	0.00
COVERED CHARGES	436,441.71	CONTRACTUAL ALLOW	297,821.94
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	138,619.77
		LESS: COB	6,179.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	132,440.43

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	56	0	71,788.00	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	56	0	71,788.00	0.00
SPECIAL CARE SERVICES				
CCU	29	0	55,941.00	0.00
ICU	2	0	5,952.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	31	0	61,893.00	0.00
TOTAL ACCOMODATIONS	87	0	133,681.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,413.95	0.00	OTHER LAB	1,174.00	0.00
MED/SURG SUPPLY	7,055.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	72,524.00	0.00	EDUCATION & TRAINING	920.00	0.00
RADIOLOGY-DIAGNOSTIC	9,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,551.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,280.21	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,994.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,399.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,578.28	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	14,144.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	490.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	742.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,995.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,655.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	796.00	0.00			

TOTAL ANCILLARY	302,760.71	0.00
TOTAL ACCOMODATIONS	133,681.00	0.00
TOTAL CHARGES	436,441.71	0.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,018,605.08	ADJUSTMENTS	140,066.85
COVERED CHARGES	3,911,047.91	CONTRACTUAL ALLOW	3,178,005.79
NON-COVERD CHARGES	107,557.17	TOTAL MEDICAID LIAB	733,042.12
		LESS: COB	1,599.14
		LESS: COPAYMENT	2,106.00
		REIMBURSEMENT	729,336.98
		ALL OTHER	674,975.59
		FEE SCHEDULE-LAB	45,855.57
		INJECTABLE DRUGS	8,505.82

TOTAL NUMBER OF CLAIMS 1,660

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,148.22	0.00	OTHER LAB	23,823.00	0.00
MED/SURG SUPPLY	21,645.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	180.00
RADIOLOGY-DIAGNOSTIC	223,235.00	4,138.00	OTHER THERAPEUTIC SVC	0.00	462.00
CT SCAN	624,078.00	36,168.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	111,508.00	1,465.00	FEE SCHEDULE LAB	518,847.00	10,601.00
EKG/ECG	49,224.00	538.00	MRI SERVICES	248,362.00	11,040.00
IV THERAPY	246,952.00	19,343.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	285,134.80	4,363.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,229.00	1,578.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,130.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,021.00	2,889.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	939,592.28	1,154.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,631.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	63,899.23	8,833.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,451.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,196.00	0.00
LITHOTRIPSY	57,611.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,456.00	2,290.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,196.00	436.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,455.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,070.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,604.00	627.00			

TOTAL ANCILLARY	3,911,047.91	107,557.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,911,047.91	107,557.17

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,272.71	ADJUSTMENTS	0.00
COVERED CHARGES	55,557.57	CONTRACTUAL ALLOW	14,546.95
NON-COVERD CHARGES	24,715.14	TOTAL MEDICAID LIAB	41,010.62
		LESS: COB	41,001.62
		LESS: COPAYMENT	9.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,860.61	23.51	OTHER LAB	806.00	0.00
MED/SURG SUPPLY	220.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,920.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,165.00	14,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,651.00	982.00
EKG/ECG	538.00	0.00	MRI SERVICES	7,969.00	0.00
IV THERAPY	4,390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,226.00	5,226.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	162.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,534.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,398.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	232.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	930.00	138.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,395.63
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,117.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,557.57	24,715.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,557.57	24,715.14

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,275.01	ADJUSTMENTS	432.00
COVERED CHARGES	177,552.01	CONTRACTUAL ALLOW	170,602.01
NON-COVERD CHARGES	5,723.00	TOTAL MEDICAID LIAB	6,950.00
		LESS: COB	39.75
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	6,700.25
		TOTAL NUMBER OF CLAIMS	139

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,499.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	635.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,398.00	363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,797.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,711.00	601.00
EKG/ECG	2,690.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,674.00	167.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	100,786.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,560.13	42.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,552.01	5,723.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,552.01	5,723.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,412.24	ADJUSTMENTS	0.00
COVERED CHARGES	3,840.24	CONTRACTUAL ALLOW	531.58
NON-COVERD CHARGES	4,572.00	TOTAL MEDICAID LIAB	3,308.66
		LESS: COB	3,305.66
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,370.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,629.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	375.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,840.24	4,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,840.24	4,572.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,083,076.87	ADJUSTMENTS	525,997.44
COVERED CHARGES	23,351,852.94	CONTRACTUAL ALLOW	14,856,028.76
NON-COVERD CHARGES	1,731,223.93	TOTAL MEDICAID LIAB	8,495,824.18
		LESS: COB	49,130.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,446,693.72

TOTAL NUMBER OF ADMISSIONS 1,158

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,520	0	4,636,516.00	1,637,144.00
ROUTINE NURSERY	403	0	410,851.00	31,799.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,923	0	5,047,367.00	1,668,943.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	966	0	1,903,088.00	0.00
NICU	30	0	112,500.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	996	0	2,015,588.00	0.00
TOTAL ACCOMODATIONS	5,919	0	7,062,955.00	1,668,943.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,214,627.64	21.11	OTHER LAB	78,057.90	0.00
MED/SURG SUPPLY	374,102.28	94.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,685,006.05	99.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390,415.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	457,750.00	10,698.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	311,116.98	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	353,130.00	0.00	MRI SERVICES	107,000.00	0.00
IV THERAPY	19,068.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,485,701.46	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	712,747.50	5,959.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,619,073.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	317,250.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,888,736.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,298.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	57,478.35	0.00	INJECTABLE DRUGS	281.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	62,014.86	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	258,153.00	12,616.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,249.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,484.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,072.00
OTHER IMAGING SERVICE	100,247.58	14,000.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	138,425.18	720.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,672.55	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	791,865.72	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,417.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	191,528.30	0.00			

TOTAL ANCILLARY	16,288,897.94	62,280.93
TOTAL ACCOMODATIONS	7,062,955.00	1,668,943.00
TOTAL CHARGES	23,351,852.94	1,731,223.93

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 01/01/18 THROUGH 12/31/18
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	2018037064943	01/18/18 - 02/01/18	02/12/18	0.00	1,000.00	0.00	0.00	0.00
615	2018094045971	03/24/18 - 03/29/18	04/09/18	0.00	1,000.00	0.00	0.00	0.00
616	2018136022644	05/04/18 - 05/08/18	05/21/18	0.00	1,000.00	0.00	0.00	0.00
615	2018138076109	03/25/18 - 04/06/18	05/21/18	0.00	1,000.00	0.00	0.00	0.00
615	2018162020011	06/01/18 - 06/03/18	06/18/18	0.00	1,000.00	0.00	0.00	0.00
615	2018184073701	03/22/18 - 03/23/18	07/09/18	0.00	1,000.00	0.00	0.00	0.00
615	2018187057452	06/16/18 - 06/30/18	07/09/18	0.00	1,000.00	0.00	0.00	0.00
615	5918213000012	01/09/18 - 02/14/18	08/06/18	0.00	1,000.00	0.00	0.00	0.00
615	2318214000148	04/25/18 - 04/28/18	09/03/18	0.00	1,000.00	0.00	653.57	0.00
615	2018218024822	07/29/18 - 07/31/18	08/13/18	0.00	1,000.00	0.00	0.00	0.00
615	2218262010057	08/16/18 - 08/20/18	09/24/18	0.00	1,000.00	0.00	0.00	0.00
615	2018289077106	10/08/18 - 10/10/18	10/22/18	0.00	1,000.00	0.00	0.00	0.00
948	2018305096304	10/15/18 - 10/21/18	11/05/18	0.00	72.00	0.00	0.00	0.00
615	2018337028675	07/24/18 - 08/03/18	12/10/18	0.00	1,000.00	0.00	0.00	0.00
615	2019002055198	12/19/18 - 12/22/18	01/07/19	0.00	1,000.00	0.00	0.00	0.00
615	2019009048016	12/27/18 - 12/30/18	01/14/19	0.00	1,000.00	0.00	0.00	0.00
615	5919057001157	11/20/18 - 12/05/18	03/04/19	0.00	1,000.00	0.00	0.00	0.00
615	2019171072508	01/24/18 - 01/26/18	06/24/19	0.00	1,000.00	0.00	0.00	0.00
615	5919227001468	04/12/18 - 04/13/18	08/19/19	0.00	1,000.00	0.00	0.00	0.00
TOTAL				0.00	18,072.00	0.00	653.57	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	218,675.31	ADJUSTMENTS	0.00
COVERED CHARGES	208,257.31	CONTRACTUAL ALLOW	77,086.13
NON-COVERD CHARGES	10,418.00	TOTAL MEDICAID LIAB	131,171.18
		LESS: COB	131,171.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	51	0	50,509.00	9,671.00
ROUTINE NURSERY	6	0	5,850.00	450.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	57	0	56,359.00	10,121.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	9,800.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	9,800.00	0.00
TOTAL ACCOMODATIONS	64	0	66,159.00	10,121.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,423.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,092.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,684.41	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,364.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,980.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	561.00	0.00	PROFESSIONAL FEES	0.00	297.00
OPERATING ROOM	18,828.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,221.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,522.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,212.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	125.30	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	555.21	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	998.52	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,368.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,391.50	0.00			

TOTAL ANCILLARY	142,098.31	297.00
TOTAL ACCOMODATIONS	66,159.00	10,121.00
TOTAL CHARGES	208,257.31	10,418.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,829,434.65	ADJUSTMENTS	476,803.69
COVERED CHARGES	14,341,523.30	CONTRACTUAL ALLOW	11,142,299.68
NON-COVERD CHARGES	1,487,911.35	TOTAL MEDICAID LIAB	3,199,223.62
		LESS: COB	11,721.43
		LESS: COPAYMENT	8,326.44
		REIMBURSEMENT	3,179,175.75
		ALL OTHER	2,746,206.30
		FEE SCHEDULE-LAB	297,783.20
		INJECTABLE DRUGS	135,186.25

TOTAL NUMBER OF CLAIMS 6,402

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,741.55	14,809.90	OTHER LAB	304,459.04	1,020.21
MED/SURG SUPPLY	156,277.85	81,492.56	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,855.00	0.00
RADIOLOGY-DIAGNOSTIC	527,479.95	28,083.02	OTHER THERAPEUTIC SVC	0.00	567.90
CT SCAN	671,165.00	65,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,242.72	31,395.39	FEE SCHEDULE LAB	1,154,775.07	131,326.38
EKG/ECG	430,935.00	5,364.00	MRI SERVICES	89,000.00	4,000.00
IV THERAPY	297,456.00	64,393.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,506,357.47	453,489.31	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,932.00	0.00	REHAB THERAPY	0.00	3,120.00
RESPIRATORY SERVICES	112,465.50	39,747.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	162,900.00	2,250.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,602,142.37	36,131.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	306,828.00	1,188.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294,409.36	241,043.05
RADIOLOGY THERAPEUTIC	22,674.80	280.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	57,617.88	10,343.94	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,378.86	2,144.37	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,262.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,763.00	7,768.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,869.72	425.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	333,431.09	29,426.64			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,171.29	12,061.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,695.68	13,483.92			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	561,045.48	181,793.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,950.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	406,503.12	749.00			

TOTAL ANCILLARY	14,341,523.30	1,487,911.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,341,523.30	1,487,911.35

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	291,423.57	ADJUSTMENTS	0.00
COVERED CHARGES	226,097.72	CONTRACTUAL ALLOW	117,714.37
NON-COVERD CHARGES	65,325.85	TOTAL MEDICAID LIAB	108,383.35
		LESS: COB	108,278.40
		LESS: COPAYMENT	104.95
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 130

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,218.37	901.06	OTHER LAB	2,373.26	0.00
MED/SURG SUPPLY	1,216.36	1,477.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,904.58	2,708.80	OTHER THERAPEUTIC SVC	0.00	99.60
CT SCAN	7,500.00	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	242.52	115.89	FEE SCHEDULE LAB	14,892.75	1,718.30
EKG/ECG	5,364.00	298.00	MRI SERVICES	0.00	4,000.00
IV THERAPY	1,296.00	0.00	PROFESSIONAL FEES	0.00	178.20
OPERATING ROOM	24,921.40	33,638.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,729.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	426.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,042.50	553.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,820.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,705.93	686.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	199.80	254.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,382.00	186.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22.63	425.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,331.36	7,998.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,897.26	2,160.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	388.00	0.00			

TOTAL ANCILLARY	226,097.72	65,325.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	226,097.72	65,325.85

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	344,246.17	ADJUSTMENTS	5,448.78
COVERED CHARGES	336,330.94	CONTRACTUAL ALLOW	322,233.83
NON-COVERD CHARGES	7,915.23	TOTAL MEDICAID LIAB	14,097.11
		LESS: COB	0.00
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	13,797.11
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	539.74	0.00	OTHER LAB	687.37	0.00
MED/SURG SUPPLY	14.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,596.00	1,392.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,500.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,338.75	3,746.13
EKG/ECG	3,874.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,822.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	271,967.50	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	4,580.40	934.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	93.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,410.22	998.52			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	336,330.94	7,915.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	336,330.94	7,915.23

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,267.60	ADJUSTMENTS	0.00
COVERED CHARGES	7,081.41	CONTRACTUAL ALLOW	3,948.06
NON-COVERD CHARGES	186.19	TOTAL MEDICAID LIAB	3,133.35
		LESS: COB	3,124.35
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	506.94	174.10	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	253.74	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	6,222.00	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	98.73	3.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,081.41	186.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,081.41	186.19

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,242,029.25	ADJUSTMENTS	22,168.92
COVERED CHARGES	1,099,535.95	CONTRACTUAL ALLOW	888,817.21
NON-COVERD CHARGES	142,493.30	TOTAL MEDICAID LIAB	210,718.74
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	210,463.74

TOTAL NUMBER OF CLAIMS 38

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,222.85	260.10	OTHER LAB	1,353.05	0.00
MED/SURG SUPPLY	60,339.26	1,647.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,770.40	2,060.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,500.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,797.93	FEE SCHEDULE LAB	16,040.60	7,072.39
EKG/ECG	12,814.00	894.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,056.50	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	423,038.04	56,370.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,344.50	900.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,760.00	184.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,922.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80,832.74	18,683.04
RADIOLOGY THERAPEUTIC	2,425.20	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	187.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,665.98	22,589.55
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	551.50	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,269.94	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,333.39	23,166.95			
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	34,646.00	0.00			

TOTAL ANCILLARY	1,099,535.95	142,493.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,099,535.95	142,493.30

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,235,266.68	ADJUSTMENTS	81,351.85
COVERED CHARGES	1,180,655.71	CONTRACTUAL ALLOW	688,565.61
NON-COVERD CHARGES	54,610.97	TOTAL MEDICAID LIAB	492,090.10
		LESS: COB	805.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	491,284.56

TOTAL NUMBER OF ADMISSIONS 131

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	233	0	124,100.00	24,470.00
ROUTINE NURSERY	112	0	59,875.00	13,558.20
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	345	0	183,975.00	38,028.20
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	345	0	183,975.00	38,028.20

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125,869.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97,857.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	108,018.42	0.00	EDUCATION & TRAINING	987.27	0.00
RADIOLOGY-DIAGNOSTIC	10,962.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,500.14	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,667.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,794.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	315,396.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	127,194.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,093.95	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,293.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,321.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,890.74	0.00	INJECTABLE DRUGS	59,000.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	120.00
OTHER IMAGING SERVICE	10,126.71	0.00			
BLOOD	0.00	8,760.57			
BLOOD STORAGE & PRO.	0.00	4,139.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	3,440.40			
CARDIOLOGY	5,455.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	250.91	122.40			

TOTAL ANCILLARY	996,680.71	16,582.77
TOTAL ACCOMODATIONS	183,975.00	38,028.20
TOTAL CHARGES	1,180,655.71	54,610.97

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 12/01/17 THROUGH 11/30/18
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	2318159000147	02/15/18 - 02/18/18	07/02/18	0.00	120.00	0.00	0.00	0.00
TOTAL				0.00	120.00	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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,636.01	ADJUSTMENTS	0.00
COVERED CHARGES	2,692.81	CONTRACTUAL ALLOW	365.76
NON-COVERD CHARGES	943.20	TOTAL MEDICAID LIAB	2,327.05
		LESS: COB	2,327.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	3	0	1,575.00	870.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,575.00	870.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,575.00	870.00

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

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	444.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	399.21	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	66.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	73.20			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,117.81	73.20
TOTAL ACCOMODATIONS	1,575.00	870.00
TOTAL CHARGES	2,692.81	943.20

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,133,541.32	ADJUSTMENTS	36,261.64
COVERED CHARGES	2,060,139.13	CONTRACTUAL ALLOW	1,683,291.31
NON-COVERD CHARGES	73,402.19	TOTAL MEDICAID LIAB	376,847.82
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	376,283.82
		ALL OTHER	316,036.47
		FEE SCHEDULE-LAB	58,258.39
		INJECTABLE DRUGS	1,988.96

TOTAL NUMBER OF CLAIMS 801

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,996.53	0.00	OTHER LAB	4,507.70	0.00
MED/SURG SUPPLY	43,078.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	107.68	EDUCATION & TRAINING	0.00	1,794.08
RADIOLOGY-DIAGNOSTIC	79,939.75	622.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	82,965.79	21,946.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	376,014.62	12,630.21
EKG/ECG	30,340.80	240.00	MRI SERVICES	0.00	0.00
IV THERAPY	51,963.27	5,062.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	749,492.26	2,701.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,263.08	8,435.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	59,262.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	228,821.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,714.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,349.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,151.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,007.50	7,765.17			
BLOOD	0.00	3,288.52			
BLOOD STORAGE & PRO.	0.00	2,035.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,767.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,654.23	3,470.58			

TOTAL ANCILLARY	2,060,139.13	73,402.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,060,139.13	73,402.19

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,488.95	ADJUSTMENTS	0.00
COVERED CHARGES	91,185.16	CONTRACTUAL ALLOW	53,519.44
NON-COVERD CHARGES	8,303.79	TOTAL MEDICAID LIAB	37,665.72
		LESS: COB	37,653.72
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,509.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,312.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	147.25	EDUCATION & TRAINING	0.00	90.23
RADIOLOGY-DIAGNOSTIC	311.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,226.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,773.54	740.87
EKG/ECG	247.20	247.20	MRI SERVICES	0.00	0.00
IV THERAPY	4,825.40	1,888.63	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,304.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	266.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,005.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,753.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	400.30	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	84.05	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,036.86	2,521.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,337.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,099.53	1,358.00			

TOTAL ANCILLARY	91,185.16	8,303.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,185.16	8,303.79

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,013.95	ADJUSTMENTS	2,996.66
COVERED CHARGES	79,677.34	CONTRACTUAL ALLOW	74,396.44
NON-COVERD CHARGES	3,336.61	TOTAL MEDICAID LIAB	5,280.90
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	5,151.90
		TOTAL NUMBER OF CLAIMS	78

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,200.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	555.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,252.63	934.41	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,800.39	1,485.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,867.61	796.60
EKG/ECG	494.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	751.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,196.02	120.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,517.88	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	520.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	515.41	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,004.64	0.00			

TOTAL ANCILLARY	79,677.34	3,336.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,677.34	3,336.61

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,078.87	ADJUSTMENTS	0.00
COVERED CHARGES	3,065.60	CONTRACTUAL ALLOW	1,951.91
NON-COVERD CHARGES	13.27	TOTAL MEDICAID LIAB	1,113.69
		LESS: COB	1,110.69
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.47	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	690.55	13.27
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	133.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,502.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	333.72	0.00			

TOTAL ANCILLARY	3,065.60	13.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,065.60	13.27

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,814.09	ADJUSTMENTS	5,751.49
COVERED CHARGES	27,800.82	CONTRACTUAL ALLOW	22,046.33
NON-COVERD CHARGES	13.27	TOTAL MEDICAID LIAB	5,754.49
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,751.49

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,441.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,247.58	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	904.24	13.27
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	21,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	688.45	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,800.82	13.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,800.82	13.27

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	309,765.23	ADJUSTMENTS	14,089.17
COVERED CHARGES	263,329.71	CONTRACTUAL ALLOW	128,728.15
NON-COVERD CHARGES	46,435.52	TOTAL MEDICAID LIAB	134,601.56
		LESS: COB	383.33
		LESS: COPAYMENT	567.00
		REIMBURSEMENT	133,651.23
		ALL OTHER	120,283.60
		FEE SCHEDULE-LAB	12,590.38
		INJECTABLE DRUGS	777.25

TOTAL NUMBER OF CLAIMS 517

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,876.80	1,092.60	OTHER LAB	1,214.31	0.00
MED/SURG SUPPLY	3,861.36	354.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,726.66	1,941.28	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,622.61	27,352.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	285.00	FEE SCHEDULE LAB	95,120.31	6,133.60
EKG/ECG	3,659.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,731.00	1,687.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	357.06	42.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,399.48	347.49	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,064.89	2,264.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,325.25	1,835.37	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,478.54	1,191.09			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,891.74	1,435.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	472.57			

TOTAL ANCILLARY	263,329.71	46,435.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	263,329.71	46,435.52

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,497.70	ADJUSTMENTS	678.02
COVERED CHARGES	12,298.48	CONTRACTUAL ALLOW	10,684.20
NON-COVERD CHARGES	199.22	TOTAL MEDICAID LIAB	1,614.28
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	1,569.28
		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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	407.30	22.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	321.48	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	1,912.55	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	85.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,520.16	41.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	973.21	73.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	62.93	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,298.48	199.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,298.48	199.22

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	740,530.09	ADJUSTMENTS	0.00
COVERED CHARGES	719,630.09	CONTRACTUAL ALLOW	460,628.99
NON-COVERD CHARGES	20,900.00	TOTAL MEDICAID LIAB	259,001.10
		LESS: COB	2,299.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	256,701.18

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	113	0	50,850.00	20,900.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	113	0	50,850.00	20,900.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	17	0	20,250.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	20,250.00	0.00
TOTAL ACCOMODATIONS	130	0	71,100.00	20,900.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,098.00	0.00	OTHER LAB	766.90	0.00
MED/SURG SUPPLY	88,559.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	133,312.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,683.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,419.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,088.00	0.00	MRI SERVICES	4,939.90	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,790.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,865.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,251.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,687.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,100.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,161.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,049.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,727.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	242.00	0.00			

TOTAL ANCILLARY	648,530.09	0.00
TOTAL ACCOMODATIONS	71,100.00	20,900.00
TOTAL CHARGES	719,630.09	20,900.00

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

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,644,465.61	ADJUSTMENTS	16,907.00
COVERED CHARGES	1,482,546.16	CONTRACTUAL ALLOW	1,086,222.98
NON-COVERD CHARGES	161,919.45	TOTAL MEDICAID LIAB	396,323.18
		LESS: COB	0.00
		LESS: COPAYMENT	1,176.00
		REIMBURSEMENT	395,147.18
		ALL OTHER	353,642.78
		FEE SCHEDULE-LAB	34,649.23
		INJECTABLE DRUGS	6,855.17

TOTAL NUMBER OF CLAIMS 1,073

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,793.00	3,137.00	OTHER LAB	41,117.40	0.00
MED/SURG SUPPLY	102,334.82	104.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,266.10	7,007.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	389,429.80	33,131.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	368,044.22	6,155.74
EKG/ECG	24,442.00	288.00	MRI SERVICES	36,728.70	3,106.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,173.00	3,491.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,440.02	8,173.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,165.80	2,278.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,744.20	31,477.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,689.00	32,485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,030.50	3,559.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,500.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	7,989.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,119.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	527.70	19,536.00			

TOTAL ANCILLARY	1,482,546.16	161,919.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,482,546.16	161,919.45

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,181.10	ADJUSTMENTS	0.00
COVERED CHARGES	5,043.10	CONTRACTUAL ALLOW	968.35
NON-COVERD CHARGES	2,138.00	TOTAL MEDICAID LIAB	4,074.75
		LESS: COB	4,050.75
		LESS: COPAYMENT	24.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	97.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	261.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	593.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,968.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,439.30	0.00
EKG/ECG	144.00	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	1,605.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	73.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,043.10	2,138.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,043.10	2,138.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	154,818.53	ADJUSTMENTS	1,550.00
COVERED CHARGES	149,470.60	CONTRACTUAL ALLOW	144,540.60
NON-COVERD CHARGES	5,347.93	TOTAL MEDICAID LIAB	4,930.00
		LESS: COB	0.00
		LESS: COPAYMENT	201.00
		REIMBURSEMENT	4,729.00
		TOTAL NUMBER OF CLAIMS	89

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,445.00	97.00	OTHER LAB	489.90	0.00
MED/SURG SUPPLY	3,097.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,928.80	226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,199.40	1,968.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,041.10	528.93
EKG/ECG	720.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	91.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,850.40	748.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,736.00	1,780.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	872.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	149,470.60	5,347.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	149,470.60	5,347.93

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,416.28	ADJUSTMENTS	4,956.41
COVERED CHARGES	19,839.28	CONTRACTUAL ALLOW	14,882.87
NON-COVERD CHARGES	1,577.00	TOTAL MEDICAID LIAB	4,956.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,956.41
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	370.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,098.28	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	4,861.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	982.00	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	2,595.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,333.00	1,071.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	506.00			

TOTAL ANCILLARY	19,839.28	1,577.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,839.28	1,577.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	403,731.92	ADJUSTMENTS	0.00
COVERED CHARGES	393,196.92	CONTRACTUAL ALLOW	118,421.84
NON-COVERD CHARGES	10,535.00	TOTAL MEDICAID LIAB	274,775.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	274,775.08

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	143	0	56,875.00	9,075.00
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	143	0	56,875.00	9,075.00
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	143	0	56,875.00	9,075.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,200.02	0.00	OTHER LAB	1,364.00	0.00
MED/SURG SUPPLY	28,413.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	190.90	0.00
RADIOLOGY-DIAGNOSTIC	6,396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,224.00	663.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,385.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	20,548.00	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	40,081.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	220.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,062.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,032.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	894.00	0.00			
BLOOD	465.00	0.00			
BLOOD STORAGE & PRO.	0.00	797.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	336,321.92	1,460.00
TOTAL ACCOMODATIONS	56,875.00	9,075.00
TOTAL CHARGES	393,196.92	10,535.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	717,372.95	ADJUSTMENTS	25,193.50
COVERED CHARGES	617,094.00	CONTRACTUAL ALLOW	421,985.91
NON-COVERD CHARGES	100,278.95	TOTAL MEDICAID LIAB	195,108.09
		LESS: COB	1,435.44
		LESS: COPAYMENT	615.00
		REIMBURSEMENT	193,057.65
		ALL OTHER	153,698.63
		FEE SCHEDULE-LAB	37,452.21
		INJECTABLE DRUGS	1,906.81

TOTAL NUMBER OF CLAIMS 1,032

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,473.00	4,603.00	OTHER LAB	21,803.00	0.00
MED/SURG SUPPLY	10,790.00	5.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	62.95
RADIOLOGY-DIAGNOSTIC	32,044.00	9,768.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,011.00	19,412.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,263.00	1,545.00	FEE SCHEDULE LAB	216,050.00	14,746.00
EKG/ECG	9,477.50	10,832.00	MRI SERVICES	1,179.00	0.00
IV THERAPY	5,163.00	1,963.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,642.00	6,222.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,828.50	1,947.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	885.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,024.00	2,116.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	189,160.00	16,762.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,830.00	2,991.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,380.00	1,947.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,772.00	2,490.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,101.00	1,527.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,796.00	958.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,422.00	382.00			

TOTAL ANCILLARY	617,094.00	100,278.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	617,094.00	100,278.95

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,961.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,224.50	CONTRACTUAL ALLOW	2,711.03
NON-COVERD CHARGES	2,737.00	TOTAL MEDICAID LIAB	4,513.47
		LESS: COB	4,508.11
		LESS: COPAYMENT	5.36
		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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	276.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,687.00	397.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,034.50	110.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	282.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,224.50	2,737.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,224.50	2,737.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,181.25	ADJUSTMENTS	3,768.02
COVERED CHARGES	71,211.00	CONTRACTUAL ALLOW	62,545.90
NON-COVERD CHARGES	7,970.25	TOTAL MEDICAID LIAB	8,665.10
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	8,446.10
		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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	551.00	134.00	OTHER LAB	608.00	0.00
MED/SURG SUPPLY	430.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,503.00	1,134.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,894.00	2,388.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,070.00	2,298.00
EKG/ECG	992.00	820.00	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	382.50	26.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,935.50	822.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,845.00	154.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	194.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	71,211.00	7,970.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	71,211.00	7,970.25

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,527.75	ADJUSTMENTS	5,545.23
COVERED CHARGES	21,836.00	CONTRACTUAL ALLOW	16,290.77
NON-COVERD CHARGES	691.75	TOTAL MEDICAID LIAB	5,545.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,545.23

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	694.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,461.00	299.00
EKG/ECG	0.00	328.00	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	8.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,923.00	56.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,284.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,836.00	691.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,836.00	691.75

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,524.88	ADJUSTMENTS	0.00
COVERED CHARGES	9,540.88	CONTRACTUAL ALLOW	5,432.99
NON-COVERD CHARGES	1,984.00	TOTAL MEDICAID LIAB	4,107.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,107.89

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	1,016.00	1,984.00
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	1,016.00	1,984.00
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	1,016.00	1,984.00

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,972.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	832.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,197.34	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	285.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	689.80	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	1,770.10	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	902.66	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	873.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,524.88	0.00
TOTAL ACCOMODATIONS	1,016.00	1,984.00
TOTAL CHARGES	9,540.88	1,984.00

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	313,075.72	ADJUSTMENTS	361.35
COVERED CHARGES	244,257.90	CONTRACTUAL ALLOW	179,541.48
NON-COVERD CHARGES	68,817.82	TOTAL MEDICAID LIAB	64,716.42
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	64,620.42
		ALL OTHER	55,563.11
		FEE SCHEDULE-LAB	9,057.31
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 263

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,605.71	0.00	OTHER LAB	5,854.05	0.00
MED/SURG SUPPLY	6,764.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,981.05	3,684.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,013.40	23,604.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,863.38	2,488.28
EKG/ECG	7,932.70	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	10,704.47	2,477.46	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,794.27	2,915.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,112.31	29,812.29	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	131.92	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,651.85	505.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,548.00	792.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	873.70	873.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,558.14	1,359.70			

TOTAL ANCILLARY	244,257.90	68,817.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	244,257.90	68,817.82

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,874.17	ADJUSTMENTS	47.00
COVERED CHARGES	15,604.65	CONTRACTUAL ALLOW	13,804.65
NON-COVERD CHARGES	269.52	TOTAL MEDICAID LIAB	1,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	1,749.00
		TOTAL NUMBER OF CLAIMS	30

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	972.56	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	566.70	131.20	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	2,564.32	72.36
EKG/ECG	517.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	586.74	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	709.50	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	9,047.85	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	65.96	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	396.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	243.18	0.00			

TOTAL ANCILLARY	15,604.65	269.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,604.65	269.52

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,541,687.32	ADJUSTMENTS	101,562.94
COVERED CHARGES	16,848,082.32	CONTRACTUAL ALLOW	11,997,458.25
NON-COVERD CHARGES	693,605.00	TOTAL MEDICAID LIAB	4,850,624.07
		LESS: COB	81,629.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,768,994.15

TOTAL NUMBER OF ADMISSIONS 516

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,622	0	2,566,004.00	478,770.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,622	0	2,566,004.00	478,770.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	747	0	2,307,042.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	747	0	2,307,042.00	0.00
TOTAL ACCOMODATIONS	2,369	0	4,873,046.00	478,770.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	948,301.00	0.00	OTHER LAB	131,516.00	0.00
MED/SURG SUPPLY	188,570.00	3,606.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,542,205.00	0.00	EDUCATION & TRAINING	2,579.00	0.00
RADIOLOGY-DIAGNOSTIC	478,646.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,410,566.00	24,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,260.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	230,914.00	0.00	MRI SERVICES	178,845.00	0.00
IV THERAPY	547,113.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,208,228.00	103.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	525,283.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	332,785.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	106,692.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,378,976.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	191,182.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,284.00
LABORATORY PATHOLOGIC	113,074.00	0.00	INJECTABLE DRUGS	749,090.62	0.00
RADIOLOGY THERAPEUTIC	5,219.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,532.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,451.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	415,544.00	107,030.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,004.00	2,745.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,300.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,140.00
OTHER IMAGING SERVICE	120,253.00	11,309.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	115,832.00	8,498.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,205.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	489,575.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,815.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	186,480.00	0.00			

TOTAL ANCILLARY	11,975,036.32	214,835.00
TOTAL ACCOMODATIONS	4,873,046.00	478,770.00
TOTAL CHARGES	16,848,082.32	693,605.00

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2217256007779	08/24/17 - 08/28/17	09/18/17	0.00	4,793.00	0.00	0.00	0.00
615	2017320087495	11/02/17 - 11/07/17	12/04/17	0.00	4,793.00	0.00	0.00	0.00
615	2017333077699	11/15/17 - 11/18/17	12/04/17	0.00	2,605.00	0.00	0.00	0.00
615	2317360000005	10/31/17 - 11/01/17	01/22/18	0.00	4,793.00	0.00	880.34	0.00
615	2318023000225	08/01/17 - 08/02/17	02/12/18	0.00	4,793.00	0.00	0.00	0.00
615	2018071030542	02/07/18 - 02/09/18	03/19/18	0.00	4,793.00	0.00	0.00	0.00
615	2218089011316	02/26/18 - 03/01/18	04/02/18	0.00	4,793.00	0.00	0.00	0.00
615	2218109003100	03/30/18 - 03/30/18	04/23/18	0.00	2,605.00	0.00	0.00	0.00
615	2018180063447	06/20/18 - 06/22/18	07/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318261000117	04/13/18 - 04/23/18	10/15/18	0.00	4,793.00	0.00	0.00	0.00
615	2018285062700	05/26/18 - 05/30/18	10/22/18	0.00	4,793.00	0.00	0.00	0.00
615	2019162003227	12/05/17 - 12/13/17	06/17/19	0.00	4,793.00	0.00	0.00	0.00
TOTAL				0.00	53,140.00	0.00	880.34	0.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,672.42	ADJUSTMENTS	0.00
COVERED CHARGES	131,432.00	CONTRACTUAL ALLOW	94,501.74
NON-COVERD CHARGES	39,240.42	TOTAL MEDICAID LIAB	36,930.26
		LESS: COB	36,930.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	27	0	37,968.00	4,746.00
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	27	0	37,968.00	4,746.00
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	27	0	37,968.00	4,746.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,873.00	1,392.00	OTHER LAB	2,023.00	0.00
MED/SURG SUPPLY	3,288.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,879.00	2,736.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957.00	428.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,084.00	10,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	826.00	366.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	439.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,147.00	827.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,065.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,479.00	354.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,348.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,273.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,855.00	2,285.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	908.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	2,301.00	INJECTABLE DRUGS	28,298.00	2,910.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	594.00	328.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,149.00	1,149.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,012.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,464.00	34,494.42
TOTAL ACCOMODATIONS	37,968.00	4,746.00
TOTAL CHARGES	131,432.00	39,240.42

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,855,363.80	ADJUSTMENTS	407,002.43
COVERED CHARGES	6,868,821.95	CONTRACTUAL ALLOW	5,634,721.94
NON-COVERD CHARGES	986,541.85	TOTAL MEDICAID LIAB	1,234,100.01
		LESS: COB	960.13
		LESS: COPAYMENT	1,500.80
		REIMBURSEMENT	1,231,639.08
		ALL OTHER	1,116,223.87
		FEE SCHEDULE-LAB	81,222.29
		INJECTABLE DRUGS	34,192.92

TOTAL NUMBER OF CLAIMS 1,999

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,207.00	53.00	OTHER LAB	99,075.00	6,860.00
MED/SURG SUPPLY	23,776.00	17,802.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	404.00
RADIOLOGY-DIAGNOSTIC	380,407.00	29,858.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,104,097.00	278,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,259.00	2,352.09	FEE SCHEDULE LAB	825,317.00	24,585.00
EKG/ECG	144,477.00	0.00	MRI SERVICES	143,658.00	49,711.00
IV THERAPY	460,062.00	29,748.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	474,719.60	133,262.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,182.00	7,539.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,374.00	3,829.00	AMBULANCE	0.00	0.00
GI SERVICES	207,159.00	18,436.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,752,685.00	5,555.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,005.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	612.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	314,797.35	56,937.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,447.00	9,150.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,761.00	3,339.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	112,225.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,363.00	2,349.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,417.00	70,200.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23,965.00
OTHER IMAGING SERVICE	153,060.00	28,827.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,986.00	8,498.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,036.00	39,900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,873.00	21,592.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,695.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	102,927.00	175.00			

TOTAL ANCILLARY	6,868,821.95	986,541.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,868,821.95	986,541.85

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017321004371	10/27/17 - 10/27/17	11/20/17	0.00	2,605.00	0.00	0.00	0.00
615	2017321004371	10/27/17 - 10/27/17	11/20/17	0.00	2,188.00	0.00	0.00	0.00
615	2018009003412	11/18/17 - 11/18/17	01/15/18	0.00	2,605.00	0.00	0.00	0.00
615	2018009003412	11/18/17 - 11/18/17	01/15/18	0.00	2,188.00	0.00	0.00	0.00
615	2018060080634	01/24/18 - 01/24/18	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018060080634	01/24/18 - 01/24/18	03/05/18	0.00	2,188.00	0.00	0.00	0.00
615	2018060080639	01/25/18 - 01/25/18	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018060080639	01/25/18 - 01/25/18	03/05/18	0.00	2,188.00	0.00	0.00	0.00
615	2018130110853	04/26/18 - 04/26/18	05/14/18	0.00	2,605.00	0.00	0.00	0.00
615	2018130110853	04/26/18 - 04/26/18	05/14/18	0.00	2,188.00	0.00	0.00	0.00
TOTAL				0.00	23,965.00	0.00	0.00	0.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,757.20	ADJUSTMENTS	0.00
COVERED CHARGES	80,421.20	CONTRACTUAL ALLOW	16,851.12
NON-COVERD CHARGES	38,336.00	TOTAL MEDICAID LIAB	63,570.08
		LESS: COB	63,563.95
		LESS: COPAYMENT	6.13
		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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,196.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	446.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,730.00	626.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	22,992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,860.00	1,132.00
EKG/ECG	439.00	0.00	MRI SERVICES	0.00	6,728.00
IV THERAPY	6,823.00	151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,512.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	127.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,185.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,930.20	1,182.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	4,207.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,769.00	1,318.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	80,421.20	38,336.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,421.20	38,336.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	495,145.60	ADJUSTMENTS	920.98
COVERED CHARGES	468,663.60	CONTRACTUAL ALLOW	454,622.66
NON-COVERD CHARGES	26,482.00	TOTAL MEDICAID LIAB	14,040.94
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	13,647.94
		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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,570.00	0.00	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	469.00	44.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,842.00	702.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,473.00	20,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,556.00	842.00
EKG/ECG	3,951.00	0.00	MRI SERVICES	3,476.00	0.00
IV THERAPY	32,866.00	755.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,914.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,012.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,164.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	233,302.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,319.60	2,070.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,451.00	1,476.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,360.00	0.00			

TOTAL ANCILLARY	468,663.60	26,482.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	468,663.60	26,482.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,104.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,708.00	CONTRACTUAL ALLOW	3,361.68
NON-COVERD CHARGES	1,396.00	TOTAL MEDICAID LIAB	2,346.32
		LESS: COB	2,346.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.00	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	1,282.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	800.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,986.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	552.00	1,324.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,708.00	1,396.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,708.00	1,396.00

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338,587.76	ADJUSTMENTS	27,617.35
COVERED CHARGES	287,532.16	CONTRACTUAL ALLOW	215,688.05
NON-COVERD CHARGES	51,055.60	TOTAL MEDICAID LIAB	71,844.11
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	71,808.11

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,218.00	0.00	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	533.00	5,354.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	702.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,648.00	893.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,034.00	1,226.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,204.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,848.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,285.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,530.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	159,736.16	41,907.60
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	1,675.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,210.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	492.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,380.00	0.00			

TOTAL ANCILLARY	287,532.16	51,055.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	287,532.16	51,055.60

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,633,896.30	ADJUSTMENTS	439,787.34
COVERED CHARGES	12,383,901.05	CONTRACTUAL ALLOW	8,589,351.85
NON-COVERD CHARGES	249,995.25	TOTAL MEDICAID LIAB	3,794,549.20
		LESS: COB	31,526.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,763,022.67

TOTAL NUMBER OF ADMISSIONS 544

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,104	0	909,690.00	143,454.00
ROUTINE NURSERY	262	0	207,572.00	11,736.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,366	0	1,117,262.00	155,190.00
SPECIAL CARE SERVICES				
CCU	267	0	399,850.00	0.00
ICU	230	0	460,230.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	497	0	860,080.00	0.00
TOTAL ACCOMODATIONS	1,863	0	1,977,342.00	155,190.00

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	576,752.81	0.00	OTHER LAB	53,104.50	0.00
MED/SURG SUPPLY	521,981.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,839,235.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205,721.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	646,273.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,069.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	160,577.75	0.00	MRI SERVICES	45,112.25	0.00
IV THERAPY	5,768.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,815,858.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	379,594.22	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	546,229.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,186.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	868,613.70	1,366.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	144,109.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	252.00	0.00	INJECTABLE DRUGS	1,044,163.47	0.00
RADIOLOGY THERAPEUTIC	5,254.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,012.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,396.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,020.00	2,500.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	229,207.75	0.00
LITHOTRIPSY	21,140.50	0.00	NO CC/INVALID REV CODE	0.00	4,948.00
OTHER IMAGING SERVICE	83,747.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	196,924.25	74,690.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,115.25	11,300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	592,062.60	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	17,075.25	0.00			

TOTAL ANCILLARY	10,406,559.05	94,805.25
TOTAL ACCOMODATIONS	1,977,342.00	155,190.00
TOTAL CHARGES	12,383,901.05	249,995.25

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017264042164	09/06/17 - 09/09/17	09/25/17	0.00	2,474.00	0.00	0.00	0.00
615	2018050021386	12/27/17 - 01/02/18	02/26/18	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	4,948.00	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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,223,644.83	ADJUSTMENTS	441,900.80
COVERED CHARGES	13,687,410.69	CONTRACTUAL ALLOW	11,371,570.68
NON-COVERD CHARGES	1,536,234.14	TOTAL MEDICAID LIAB	2,315,840.01
		LESS: COB	1,069.70
		LESS: COPAYMENT	9,007.56
		REIMBURSEMENT	2,305,762.75
		ALL OTHER	1,949,711.12
		FEE SCHEDULE-LAB	161,131.24
		INJECTABLE DRUGS	194,920.39

TOTAL NUMBER OF CLAIMS 4,652

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,883.50	771.38	OTHER LAB	94,734.50	1,309.50
MED/SURG SUPPLY	314,652.31	15,451.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	606,655.25	13,350.00	OTHER THERAPEUTIC SVC	735.00	735.00
CT SCAN	1,891,781.75	268,437.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	81,602.25	16,905.25	FEE SCHEDULE LAB	1,730,535.14	64,154.75
EKG/ECG	219,162.50	8,827.00	MRI SERVICES	483,352.00	9,536.25
IV THERAPY	193,246.75	3,969.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,384,205.58	354,284.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303,386.25	91,101.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	248,141.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,546,460.92	51,665.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	134,902.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,746.96	100,864.42
RADIOLOGY THERAPEUTIC	654,157.01	85,533.81	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,173.75	6,504.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,235.50	3,707.83	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	114,150.96	14,310.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,941.99	52,946.90
LITHOTRIPSY	126,843.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	391,468.25	41,015.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,283.50	11,731.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	244,178.00	97,969.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	332,956.00	146,626.75			
AMBULATORY SURGERY	87,834.75	30,174.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	155,540.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816,464.00	42,850.11			

TOTAL ANCILLARY	13,687,410.69	1,534,734.14
TOTAL ACCOMODATIONS	0.00	1,500.00
TOTAL CHARGES	13,687,410.69	1,536,234.14

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	58,564.18	ADJUSTMENTS	0.00
COVERED CHARGES	45,104.38	CONTRACTUAL ALLOW	21,509.94
NON-COVERD CHARGES	13,459.80	TOTAL MEDICAID LIAB	23,594.44
		LESS: COB	23,567.44
		LESS: COPAYMENT	27.00
		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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.40	3.00	OTHER LAB	688.50	0.00
MED/SURG SUPPLY	958.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,833.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,585.00	2,675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,082.50	332.00	FEE SCHEDULE LAB	7,476.50	356.50
EKG/ECG	315.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,805.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	920.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,578.75	583.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	589.14	483.20
RADIOLOGY THERAPEUTIC	269.00	6,412.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	236.75	236.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	482.50	297.00	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	NO CC/INVALID REV CODE	0.00	67.60
OTHER IMAGING SERVICE	1,224.25	631.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,412.50	487.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	894.25			

TOTAL ANCILLARY	45,104.38	13,459.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,104.38	13,459.80

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2217244009844	07/27/17 - 07/27/17	09/04/17	0.00	67.60	0.00	3,073.49	0.00
TOTAL				0.00	67.60	0.00	3,073.49	0.00

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	963,534.89	ADJUSTMENTS	964.92
COVERED CHARGES	929,215.81	CONTRACTUAL ALLOW	901,559.07
NON-COVERD CHARGES	34,319.08	TOTAL MEDICAID LIAB	27,656.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,050.00
		REIMBURSEMENT	26,606.74
		TOTAL NUMBER OF CLAIMS	494

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,950.08	35.00	OTHER LAB	3,627.75	0.00
MED/SURG SUPPLY	6,624.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	125.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,235.25	2,881.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	171,463.00	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	171,500.75	6,038.50
EKG/ECG	25,220.00	1,261.00	MRI SERVICES	11,902.25	0.00
IV THERAPY	1,332.00	545.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,110.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	451,092.35	8,436.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,719.32	35.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	272.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,897.75	6,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,639.25	540.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,629.00	0.00			

TOTAL ANCILLARY	929,215.81	34,319.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	929,215.81	34,319.08

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,069.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,069.00	CONTRACTUAL ALLOW	1,066.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	354.00	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	715.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,069.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,069.00	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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,559,702.11	ADJUSTMENTS	64,107.33
COVERED CHARGES	1,465,543.62	CONTRACTUAL ALLOW	1,103,206.95
NON-COVERD CHARGES	94,158.49	TOTAL MEDICAID LIAB	362,336.67
		LESS: COB	0.00
		LESS: COPAYMENT	904.64
		REIMBURSEMENT	361,432.03

TOTAL NUMBER OF CLAIMS 62

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,124.43	35.00	OTHER LAB	2,289.50	0.00
MED/SURG SUPPLY	47,575.02	4,883.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,331.00	1,748.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,491.25	8,375.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	716.75	FEE SCHEDULE LAB	52,271.75	2,793.00
EKG/ECG	3,467.75	315.25	MRI SERVICES	4,076.00	4,152.50
IV THERAPY	27,478.25	545.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	152,364.00	10,996.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	261,822.00	27,940.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,013.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,669.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	426,707.32	2,855.47
RADIOLOGY THERAPEUTIC	212,788.44	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,072.50	3,379.13	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,833.46	17,738.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,845.75	1,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,667.00	1,940.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,162.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,001.50	2,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	89,317.50	730.25			

TOTAL ANCILLARY	1,465,543.62	94,158.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,465,543.62	94,158.49

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,590,934.48	ADJUSTMENTS	1,003,909.09
COVERED CHARGES	28,170,089.96	CONTRACTUAL ALLOW	22,925,330.71
NON-COVERD CHARGES	1,420,844.52	TOTAL MEDICAID LIAB	5,244,759.25
		LESS: COB	20,853.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,223,905.49

TOTAL NUMBER OF ADMISSIONS 812

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,340	0	2,838,820.00	593,037.00
ROUTINE NURSERY	867	0	1,109,335.00	358,483.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,207	0	3,948,155.00	951,520.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	285	0	1,226,843.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	285	0	1,226,843.00	0.00
TOTAL ACCOMODATIONS	3,492	0	5,174,998.00	951,520.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,131,411.74	38,720.50	OTHER LAB	91,686.00	0.00
MED/SURG SUPPLY	998,956.50	2,127.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,580,931.14	56,366.02	EDUCATION & TRAINING	1,219.00	0.00
RADIOLOGY-DIAGNOSTIC	358,987.00	429.00	OTHER THERAPEUTIC SVC	0.00	3,213.00
CT SCAN	1,282,568.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	201,125.00	2,757.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	134,080.00	0.00	MRI SERVICES	403,474.00	5,276.00
IV THERAPY	47,604.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,116,288.00	12,444.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	966,675.00	3,268.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,444,621.00	39.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	325,077.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	763,212.00	74.00	SPECIAL SERVICES	0.00	73,772.00
RECOVERY ROOM	255,044.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	59,046.00
LABORATORY PATHOLOGIC	215,130.00	0.00	INJECTABLE DRUGS	4,372,294.50	92,926.00
RADIOLOGY THERAPEUTIC	21,014.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,065.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,426.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	172,520.00	0.00	PATIENT CONVENIENCE	0.00	380.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.00	193.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	537,390.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,282.00	44,166.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	324,223.00	55,258.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	120,766.08	18,870.00			
AUDIOLOGY	101,809.00	0.00			
CARDIOLOGY	625,478.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,558.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,137.00	0.00			

TOTAL ANCILLARY	22,995,091.96	469,324.52
TOTAL ACCOMODATIONS	5,174,998.00	951,520.00
TOTAL CHARGES	28,170,089.96	1,420,844.52

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	603,010.00	ADJUSTMENTS	0.00
COVERED CHARGES	595,663.00	CONTRACTUAL ALLOW	301,282.70
NON-COVERD CHARGES	7,347.00	TOTAL MEDICAID LIAB	294,380.30
		LESS: COB	294,380.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	42	0	52,365.00	2,235.00
ROUTINE NURSERY	8	0	29,758.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	50	0	82,123.00	2,235.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	22,005.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	22,005.00	0.00
TOTAL ACCOMODATIONS	55	0	104,128.00	2,235.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,603.50	0.00	OTHER LAB	2,066.00	0.00
MED/SURG SUPPLY	37,767.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	41,649.00	0.00	EDUCATION & TRAINING	83.00	0.00
RADIOLOGY-DIAGNOSTIC	8,878.00	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	2,576.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,429.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,781.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,021.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,510.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,065.00	0.00	SPECIAL SERVICES	0.00	5,112.00
RECOVERY ROOM	5,472.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,439.00	0.00	INJECTABLE DRUGS	27,321.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,098.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	565.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,728.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,218.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,496.00	0.00			
AUDIOLOGY	863.00	0.00			
CARDIOLOGY	79,906.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	491,535.00	5,112.00
TOTAL ACCOMODATIONS	104,128.00	2,235.00
TOTAL CHARGES	595,663.00	7,347.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,516,310.74	ADJUSTMENTS	862,894.88
COVERED CHARGES	16,907,684.24	CONTRACTUAL ALLOW	14,576,298.65
NON-COVERD CHARGES	1,608,626.50	TOTAL MEDICAID LIAB	2,331,385.59
		LESS: COB	6,531.12
		LESS: COPAYMENT	5,540.52
		REIMBURSEMENT	2,319,313.95
		ALL OTHER	1,957,575.16
		FEE SCHEDULE-LAB	143,036.67
		INJECTABLE DRUGS	218,702.12

TOTAL NUMBER OF CLAIMS 3,210

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343,744.20	6,128.00	OTHER LAB	218,062.00	1,198.00
MED/SURG SUPPLY	360,321.50	3,885.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,386.00	0.00
RADIOLOGY-DIAGNOSTIC	502,515.00	13,537.00	OTHER THERAPEUTIC SVC	0.00	691.00
CT SCAN	2,126,556.00	167,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169,830.00	24,564.00	FEE SCHEDULE LAB	2,361,898.33	85,448.00
EKG/ECG	199,708.00	1,104.00	MRI SERVICES	717,725.00	88,336.00
IV THERAPY	342,958.00	39,378.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,295,375.00	88,704.00	DURABLE MED. EQUIP.	0.00	8,454.00
LABOR/DELIVERY ROOM	36,885.00	0.00	REHAB THERAPY	0.00	285.00
RESPIRATORY SERVICES	93,667.00	186.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	302,777.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,952,035.00	93,458.00	SPECIAL SERVICES	0.00	516.00
RECOVERY ROOM	260,966.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,552.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,060,147.00	749,346.50
RADIOLOGY THERAPEUTIC	1,212,883.00	3,479.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	64,371.00	23,367.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,146.00	20,419.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	15,438.00	PATIENT CONVENIENCE	0.00	95.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	49,027.00	1,879.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,640.00	880.00	IMPL DEV CHARGE PATIENTS	178,140.00	2,385.00
LITHOTRIPSY	24,520.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	534,239.00	99,563.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,693.00	1,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	101,570.00	16,871.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	220,434.00	45,149.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,171.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124,294.21	3,411.00			

TOTAL ANCILLARY	16,907,684.24	1,608,626.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,907,684.24	1,608,626.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	552,739.00	ADJUSTMENTS	0.00
COVERED CHARGES	398,002.00	CONTRACTUAL ALLOW	192,148.92
NON-COVERD CHARGES	154,737.00	TOTAL MEDICAID LIAB	205,853.08
		LESS: COB	205,744.37
		LESS: COPAYMENT	108.71
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,205.00	0.00	OTHER LAB	1,395.00	0.00
MED/SURG SUPPLY	10,743.00	474.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,509.00	393.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,503.00	20,548.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,946.00	1,252.00	FEE SCHEDULE LAB	64,389.00	7,034.00
EKG/ECG	2,594.00	0.00	MRI SERVICES	5,276.00	0.00
IV THERAPY	9,916.00	382.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,108.00	38,351.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,076.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,183.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,926.00	6,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,704.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,646.00	54,095.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	386.00	42.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	440.00	IMPL DEV CHARGE PATIENTS	1,982.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,409.00	25,194.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,876.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,798.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,934.00	0.00			

TOTAL ANCILLARY	398,002.00	154,737.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	398,002.00	154,737.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	364,238.50	ADJUSTMENTS	3,285.29
COVERED CHARGES	341,344.50	CONTRACTUAL ALLOW	329,115.92
NON-COVERD CHARGES	22,894.00	TOTAL MEDICAID LIAB	12,228.58
		LESS: COB	0.00
		LESS: COPAYMENT	246.00
		REIMBURSEMENT	11,982.58
		TOTAL NUMBER OF CLAIMS	209

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,490.00	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	23,005.00	1,563.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,675.00	7,661.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	71,918.00	6,253.00
EKG/ECG	4,416.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	176,102.00	1,554.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,725.50	109.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	42.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,732.00	1,884.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,891.00	3,828.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	341,344.50	22,894.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	341,344.50	22,894.00

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
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,781.00	ADJUSTMENTS	0.00
COVERED CHARGES	47,340.50	CONTRACTUAL ALLOW	29,662.10
NON-COVERD CHARGES	3,440.50	TOTAL MEDICAID LIAB	17,678.40
		LESS: COB	17,657.40
		LESS: COPAYMENT	21.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621.00	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	492.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,154.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,311.00	1,422.00
EKG/ECG	368.00	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	20,363.00	1,204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,307.50	772.50
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	42.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,724.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,340.50	3,440.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,340.50	3,440.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,329,280.56	ADJUSTMENTS	103,323.40
COVERED CHARGES	2,831,073.06	CONTRACTUAL ALLOW	2,515,894.25
NON-COVERD CHARGES	498,207.50	TOTAL MEDICAID LIAB	315,178.81
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	314,995.81

TOTAL NUMBER OF CLAIMS 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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,553.50	1,219.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	199,245.50	99.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,149.00	49,129.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,957.00	11,070.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,425.00	FEE SCHEDULE LAB	66,579.00	2,356.00
EKG/ECG	6,992.00	590.00	MRI SERVICES	24,391.00	9,866.00
IV THERAPY	68,889.00	7,159.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	525,466.00	146,520.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,495.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,485.00	772.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,061.00	1,317.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,328.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,102,645.50	230,182.50
RADIOLOGY THERAPEUTIC	23,899.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,938.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	800.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,292.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,383.00	225.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	455,634.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,559.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,774.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,766.00	11,424.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,921.00	2,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,196.56	3,627.00			

TOTAL ANCILLARY	2,831,073.06	498,207.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,831,073.06	498,207.50

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
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	155,702,064.80	ADJUSTMENTS	4,375,451.00
COVERED CHARGES	148,802,979.16	CONTRACTUAL ALLOW	122,159,988.79
NON-COVERD CHARGES	6,899,085.64	TOTAL MEDICAID LIAB	26,642,990.37
		LESS: COB	276,522.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,366,468.08

TOTAL NUMBER OF ADMISSIONS 2,676

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,164	0	10,349,732.00	778,243.00
ROUTINE NURSERY	2,396	0	2,877,677.00	531,079.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,560	0	13,227,409.00	1,309,322.00
SPECIAL CARE SERVICES				
CCU	2,916	0	7,453,232.00	221,137.00
ICU	1,830	0	5,954,458.50	353,421.50
NICU	767	0	2,436,464.00	189,236.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	92	0	441,652.00	53,860.00
BURN UNIT	6	0	32,316.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,611	0	16,318,122.50	817,654.50
TOTAL ACCOMODATIONS	16,171	0	29,545,531.50	2,126,976.50

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,911,602.79	917,107.30	OTHER LAB	1,157,874.10	40,127.90
MED/SURG SUPPLY	6,436,767.81	266,068.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,292,894.75	589,957.00	EDUCATION & TRAINING	53,834.00	0.00
RADIOLOGY-DIAGNOSTIC	2,982,128.00	158,340.00	OTHER THERAPEUTIC SVC	0.00	16,186.00
CT SCAN	8,671,353.00	91,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	890,143.02	31,012.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,017,595.00	17,408.00	MRI SERVICES	1,773,386.00	9,356.00
IV THERAPY	1,492,817.00	22,762.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,547,705.49	746,256.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,503,064.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,787,080.00	786,620.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,025,034.20	49,827.00	AMBULANCE	0.00	0.00
GI SERVICES	76,591.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,658,565.00	10,430.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,823,211.00	5,311.00	DRUG-SPECIFIC/HOME IV	0.00	25,480.75
LABORATORY PATHOLOGIC	693,019.70	324.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	357,516.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	329,710.44	4,538.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	394,817.35	36,236.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,166,269.00	371,250.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	76,494.00	45,825.00	TRAUMA RESPONSE	0.00	187,357.00
PSYCHIATRIC SERVICES	7,751.00	0.00	IMPL DEV CHARGE PATIENTS	5,006,482.84	4,685.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	603,021.00	9,178.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,337,673.00	279,919.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	394,398.00	2,117.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,055,046.00	19,147.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	843,273.00	21,832.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,890,330.17	5,744.00			

TOTAL ANCILLARY	119,257,447.66	4,772,109.14
TOTAL ACCOMODATIONS	29,545,531.50	2,126,976.50
TOTAL CHARGES	148,802,979.16	6,899,085.64

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,168,334.28	ADJUSTMENTS	0.00
COVERED CHARGES	2,154,451.28	CONTRACTUAL ALLOW	1,373,105.92
NON-COVERD CHARGES	13,883.00	TOTAL MEDICAID LIAB	781,345.36
		LESS: COB	781,345.36
		LESS: COPAYMENT	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	111	0	143,412.00	6,216.00
ROUTINE NURSERY	63	0	124,066.00	3,564.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	174	0	267,478.00	9,780.00
SPECIAL CARE SERVICES				
CCU	57	0	143,298.00	0.00
ICU	19	0	55,305.00	0.00
NICU	7	0	23,954.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	83	0	222,557.00	0.00
TOTAL ACCOMODATIONS	257	0	490,035.00	9,780.00

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,839.50	0.00	OTHER LAB	20,018.00	0.00
MED/SURG SUPPLY	53,141.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	175,103.00	0.00	EDUCATION & TRAINING	4,198.00	0.00
RADIOLOGY-DIAGNOSTIC	17,844.00	0.00	OTHER THERAPEUTIC SVC	0.00	598.00
CT SCAN	81,423.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,895.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,144.00	0.00	MRI SERVICES	9,228.00	0.00
IV THERAPY	14,724.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	258,395.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	308,459.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	51,063.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,475.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,987.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,811.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	928.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,189.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,637.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	11,976.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,443.00	2,113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,517.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,149.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	125,833.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,834.00	1,392.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,279.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,179.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,671.64	0.00			

TOTAL ANCILLARY	1,664,416.28	4,103.00
TOTAL ACCOMODATIONS	490,035.00	9,780.00
TOTAL CHARGES	2,154,451.28	13,883.00

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,848,450.05	ADJUSTMENTS	687,231.36
COVERED CHARGES	33,545,882.24	CONTRACTUAL ALLOW	29,408,279.68
NON-COVERD CHARGES	3,302,567.81	TOTAL MEDICAID LIAB	4,137,602.56
		LESS: COB	55,701.61
		LESS: COPAYMENT	9,619.31
		REIMBURSEMENT	4,072,281.64
		ALL OTHER	3,686,984.40
		FEE SCHEDULE-LAB	364,093.44
		INJECTABLE DRUGS	21,203.80

TOTAL NUMBER OF CLAIMS 9,640

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	813,713.72	1,061.65	OTHER LAB	727,338.00	1,268.00
MED/SURG SUPPLY	513,127.92	31,331.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	912.00
RADIOLOGY-DIAGNOSTIC	1,456,577.00	19,950.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,596,871.00	648,609.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	142,828.00	36,613.02	FEE SCHEDULE LAB	4,965,711.91	339,862.33
EKG/ECG	446,176.00	8,284.00	MRI SERVICES	1,334,482.00	154,050.00
IV THERAPY	1,375,304.00	78,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,032,160.18	422,044.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,516.00	0.00	REHAB THERAPY	0.00	594.00
RESPIRATORY SERVICES	193,482.00	78,224.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	910,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,649.00	4,863.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,644,665.50	100,490.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476,877.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,887.85	170,167.23
RADIOLOGY THERAPEUTIC	1,479,790.00	120,257.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	76,035.00	20,025.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,910.00	16,512.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	59,880.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	298,697.86	65,941.79	TRAUMA RESPONSE	0.00	24,297.00
PSYCHIATRIC SERVICES	73,400.00	139,011.00	IMPL DEV CHARGE PATIENTS	123,898.94	2,477.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	77.00	328.06
OTHER IMAGING SERVICE	1,135,470.00	340,852.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,285.00	1,765.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	512,584.00	51,709.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	942,497.00	265,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	232,810.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	806,476.36	97,165.73			

TOTAL ANCILLARY	33,545,882.24	3,302,567.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,545,882.24	3,302,567.81

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
3021	5917248000322	08/09/17 - 08/09/17	09/11/17	0.00	75.00	0.00	0.00	0.00
780	2017278054379	09/07/17 - 09/07/17	11/13/17	77.00	0.00	0.00	0.00	20.52
780	2017278054379	09/07/17 - 09/07/17	11/13/17	0.00	80.00	0.00	0.00	0.00
8779	5918164000637	03/15/18 - 03/15/18	06/18/18	0.00	173.06	0.00	0.00	0.00
TOTAL				77.00	328.06	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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	797,882.04	ADJUSTMENTS	0.00
COVERED CHARGES	620,700.11	CONTRACTUAL ALLOW	321,477.44
NON-COVERD CHARGES	177,181.93	TOTAL MEDICAID LIAB	299,222.67
		LESS: COB	299,103.05
		LESS: COPAYMENT	119.62
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	182

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,816.39	2,222.00	OTHER LAB	31,767.00	0.00
MED/SURG SUPPLY	9,939.77	1,412.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	378.00
RADIOLOGY-DIAGNOSTIC	26,402.00	7,346.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,011.00	45,097.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99,210.50	13,281.09
EKG/ECG	3,628.00	0.00	MRI SERVICES	20,006.00	4,678.00
IV THERAPY	43,430.00	2,851.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,026.00	45,506.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,167.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,254.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,093.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,235.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,458.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	694.25	314.00
RADIOLOGY THERAPEUTIC	26,961.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	474.00	2,358.79	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	766.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,656.00	23,960.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,008.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,829.00	21,507.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,480.20	4,497.00			

TOTAL ANCILLARY	620,700.11	177,181.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	620,700.11	177,181.93

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	970,595.99	ADJUSTMENTS	435.52
COVERED CHARGES	921,210.01	CONTRACTUAL ALLOW	900,413.81
NON-COVERD CHARGES	49,385.98	TOTAL MEDICAID LIAB	20,796.20
		LESS: COB	657.80
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	19,649.40
		TOTAL NUMBER OF CLAIMS	360

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,789.00	0.00	OTHER LAB	19,870.00	0.00
MED/SURG SUPPLY	5,034.09	202.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,281.00	3,038.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	117,509.00	13,653.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	159,155.00	9,070.00
EKG/ECG	8,704.00	0.00	MRI SERVICES	16,885.00	0.00
IV THERAPY	45,498.00	2,416.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,879.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,304.00	1,108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,683.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	438,040.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,160.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	5,746.00	10,304.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,236.00	9,579.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,129.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,334.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,973.92	0.00			

TOTAL ANCILLARY	921,210.01	49,385.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,210.01	49,385.98

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,949.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,511.00	CONTRACTUAL ALLOW	22,445.18
NON-COVERD CHARGES	438.00	TOTAL MEDICAID LIAB	18,065.82
		LESS: COB	18,056.82
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	410.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,999.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,595.00	438.00
EKG/ECG	512.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,047.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	18,134.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,511.00	438.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,511.00	438.00

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,249,429.37	ADJUSTMENTS	180,706.60
COVERED CHARGES	3,962,976.01	CONTRACTUAL ALLOW	3,660,900.83
NON-COVERD CHARGES	286,453.36	TOTAL MEDICAID LIAB	302,075.18
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	301,736.18

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

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677 CHURCH ST NE
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,684.25	0.00
MED/SURG SUPPLY	503,705.17	107.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,075.00	111,592.00
CT SCAN	56,806.00	7,967.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,536.00	0.00
IV THERAPY	1,253.00	542.00
OPERATING ROOM	758,324.75	119,121.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,018.00	0.00
ANESTHESIA	242,285.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,500.00	0.00
RECOVERY ROOM	90,938.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	491,697.00	4,456.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	111.00	111.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,475.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,414.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	610,522.00	33,487.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,907.41	0.00
OTHER LAB	365.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,105.00	656.00
MRI SERVICES	4,678.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,640.25	2,939.25
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	1,041,936.18	5,474.86
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,962,976.01	286,453.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,962,976.01	286,453.36

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	142,564.34	ADJUSTMENTS	0.00
COVERED CHARGES	142,564.34	CONTRACTUAL ALLOW	77,335.45
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	65,228.89
		LESS: COB	65,225.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	586.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,038.53	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	7,109.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,226.00	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	4,140.00	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	124,464.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	142,564.34	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	142,564.34	0.00

** END OF REPORT **

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,072,206.25	ADJUSTMENTS	356,044.89
COVERED CHARGES	37,219,264.60	CONTRACTUAL ALLOW	31,127,475.68
NON-COVERD CHARGES	852,941.65	TOTAL MEDICAID LIAB	6,091,788.92
		LESS: COB	49,161.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,042,627.42

TOTAL NUMBER OF ADMISSIONS 644

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,379	0	2,373,565.00	294,502.00
ROUTINE NURSERY	86	0	63,596.00	1,541.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,465	0	2,437,161.00	296,043.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	655	0	1,819,156.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	655	0	1,819,156.00	0.00
TOTAL ACCOMODATIONS	3,120	0	4,256,317.00	296,043.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,258,765.69	1,797.50	OTHER LAB	127,532.50	0.00
MED/SURG SUPPLY	2,199,449.80	22,701.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,400,753.50	1,785.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802,057.25	0.00	OTHER THERAPEUTIC SVC	0.00	14,264.00
CT SCAN	1,492,452.00	314,531.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	651,382.22	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	344,110.00	0.00	MRI SERVICES	262,939.00	0.00
IV THERAPY	16,182.00	126.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,371,851.75	3,394.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	160,235.00	0.00	REHAB THERAPY	197.00	0.00
RESPIRATORY SERVICES	1,846,339.25	1,308.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242,663.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,313.00	5,798.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,203,270.00	632.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	205,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	33,656.50
LABORATORY PATHOLOGIC	63,197.75	0.00	INJECTABLE DRUGS	8,042,424.21	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	464,329.57	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	101,712.15	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	238,792.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,578.25	1,623.00	TRAUMA RESPONSE	0.00	19,600.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	526,831.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	234,561.75	7,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	75,721.16	125,414.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	281,520.00	2,345.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,121,918.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,214.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,514.75	0.00			

TOTAL ANCILLARY	32,962,947.60	556,898.65
TOTAL ACCOMODATIONS	4,256,317.00	296,043.00
TOTAL CHARGES	37,219,264.60	852,941.65

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 05/01/17 THROUGH 04/30/18
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	2017171002460	05/30/17 - 06/12/17	06/26/17	0.00	0.00	0.00	0.00	0.00
24	2017244092888	08/02/17 - 08/24/17	09/11/17	0.00	0.00	0.00	0.00	0.00
24	2017296027107	09/26/17 - 10/13/17	10/30/17	0.00	0.00	0.00	0.00	0.00
24	2017314070984	10/23/17 - 11/01/17	11/20/17	0.00	0.00	0.00	0.00	0.00
24	2018025099854	01/03/18 - 01/19/18	01/29/18	0.00	0.00	0.00	0.00	0.00
24	2018088091142	03/13/18 - 03/23/18	04/02/18	0.00	0.00	0.00	0.00	0.00
24	2019052098963	12/08/17 - 12/29/17	02/25/19	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,126.50	ADJUSTMENTS	0.00
COVERED CHARGES	39,817.50	CONTRACTUAL ALLOW	19,935.03
NON-COVERD CHARGES	1,309.00	TOTAL MEDICAID LIAB	19,882.47
		LESS: COB	19,882.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	4,909.00	697.00
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	4,909.00	697.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	4,909.00	697.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,649.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	788.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,532.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,277.50	0.00	OTHER THERAPEUTIC SVC	0.00	612.00
CT SCAN	3,950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	800.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	577.00	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	4,294.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,150.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,875.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,014.00	0.00			

TOTAL ANCILLARY	34,908.50	612.00
TOTAL ACCOMODATIONS	4,909.00	697.00
TOTAL CHARGES	39,817.50	1,309.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,802,151.95	ADJUSTMENTS	74,631.73
COVERED CHARGES	23,023,281.03	CONTRACTUAL ALLOW	21,432,135.89
NON-COVERD CHARGES	2,778,870.92	TOTAL MEDICAID LIAB	1,591,145.14
		LESS: COB	138.75
		LESS: COPAYMENT	3,989.73
		REIMBURSEMENT	1,587,016.66
		ALL OTHER	1,361,201.98
		FEE SCHEDULE-LAB	205,713.42
		INJECTABLE DRUGS	20,101.26

TOTAL NUMBER OF CLAIMS 4,551

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,631.80	120,086.45	OTHER LAB	136,542.00	0.00
MED/SURG SUPPLY	1,183,247.90	10,366.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,139,701.25	225,633.35	OTHER THERAPEUTIC SVC	0.00	184.00
CT SCAN	4,224,687.00	347,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	166,525.00	6,566.50	FEE SCHEDULE LAB	5,638,319.50	426,185.50
EKG/ECG	517,149.00	1,451.00	MRI SERVICES	380,434.00	5,048.00
IV THERAPY	428,148.00	38,844.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,609,891.25	365,554.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,100.00	982.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	97,836.08	15,627.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	521,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	310,263.27	141,385.93	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,442,377.00	38,951.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	203,354.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	645,310.04	549,031.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,323.00	574.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,158.00	2,226.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,520.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102,370.50	15,973.75	TRAUMA RESPONSE	0.00	153,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	148,678.30	0.00
LITHOTRIPSY	28,721.00	28,721.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	397,122.25	35,604.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,655.98	16,088.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	232,483.00	52,075.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	537,531.00	70,677.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	264,015.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	443,511.91	108,589.62			

TOTAL ANCILLARY	23,023,281.03	2,778,870.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,023,281.03	2,778,870.92

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	344,714.75	ADJUSTMENTS	0.00
COVERED CHARGES	292,997.30	CONTRACTUAL ALLOW	192,404.65
NON-COVERD CHARGES	51,717.45	TOTAL MEDICAID LIAB	100,592.65
		LESS: COB	100,562.65
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 53

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,625.45	6,571.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,594.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,063.25	1,643.00	OTHER THERAPEUTIC SVC	0.00	220.00
CT SCAN	49,226.00	16,906.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	76,309.25	8,001.00
EKG/ECG	6,176.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,642.00	994.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,754.00	4,711.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,103.00	1,642.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	879.00	1,419.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,010.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,324.00	1,513.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,337.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,627.75	5,388.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,141.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	115.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,471.00	900.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,770.00	708.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,361.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,467.00	1,100.00			

TOTAL ANCILLARY	292,997.30	51,717.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	292,997.30	51,717.45

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,131,122.14	ADJUSTMENTS	0.00
COVERED CHARGES	1,045,301.28	CONTRACTUAL ALLOW	1,026,169.80
NON-COVERD CHARGES	85,820.86	TOTAL MEDICAID LIAB	19,131.48
		LESS: COB	30.46
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	18,549.02
		TOTAL NUMBER OF CLAIMS	342

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,294.71	5,285.11	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,605.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,010.50	23,488.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	158,562.00	18,986.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	342,369.50	19,435.25
EKG/ECG	23,895.00	0.00	MRI SERVICES	5,411.00	0.00
IV THERAPY	27,123.00	864.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,325.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	342,201.00	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	28,052.22	15,802.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,869.25	1,960.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,690.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	893.00	0.00			

TOTAL ANCILLARY	1,045,301.28	85,820.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,045,301.28	85,820.86

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,766.55	ADJUSTMENTS	0.00
COVERED CHARGES	7,377.05	CONTRACTUAL ALLOW	2,795.76
NON-COVERD CHARGES	389.50	TOTAL MEDICAID LIAB	4,581.29
		LESS: COB	4,578.29
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 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	344.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,206.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,916.00	48.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	220.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,215.00	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	474.50	341.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,377.05	389.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,377.05	389.50

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	727,312.24	ADJUSTMENTS	11,075.46
COVERED CHARGES	710,641.09	CONTRACTUAL ALLOW	679,109.86
NON-COVERD CHARGES	16,671.15	TOTAL MEDICAID LIAB	31,531.23
		LESS: COB	9,124.34
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	22,370.89

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,675.75	5,743.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42,228.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,574.50	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	20,162.25	1,560.00
EKG/ECG	3,175.00	577.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290,411.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	573.00	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	4,757.00	7,825.75
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	189,143.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	675.04	965.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	147,697.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.00	0.00			

TOTAL ANCILLARY	710,641.09	16,671.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	710,641.09	16,671.15

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,522,454.33	ADJUSTMENTS	117,400.62
COVERED CHARGES	1,514,535.08	CONTRACTUAL ALLOW	944,847.30
NON-COVERD CHARGES	7,919.25	TOTAL MEDICAID LIAB	569,687.78
		LESS: COB	3,062.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	566,625.72

TOTAL NUMBER OF ADMISSIONS 85

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	240	0	229,200.00	6,443.00
ROUTINE NURSERY	18	0	7,794.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	258	0	236,994.00	6,443.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	24	0	36,528.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	36,528.00	0.00
TOTAL ACCOMODATIONS	282	0	273,522.00	6,443.00

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,936.78	0.00	OTHER LAB	13,969.00	0.00
MED/SURG SUPPLY	64,575.48	94.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	281,914.03	0.00	EDUCATION & TRAINING	2,445.00	0.00
RADIOLOGY-DIAGNOSTIC	23,120.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,422.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,300.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,071.00	0.00	MRI SERVICES	21,064.00	0.00
IV THERAPY	88,224.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,048.25	884.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,078.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,668.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,965.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,617.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,047.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	84,395.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,060.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,861.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	692.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,977.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,513.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,651.00	0.00			
AUDIOLOGY	83.00	498.00			
CARDIOLOGY	13,992.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,699.13	0.00			

TOTAL ANCILLARY	1,241,013.08	1,476.25
TOTAL ACCOMODATIONS	273,522.00	6,443.00
TOTAL CHARGES	1,514,535.08	7,919.25

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,936,338.88	ADJUSTMENTS	261,733.66
COVERED CHARGES	4,549,886.93	CONTRACTUAL ALLOW	3,682,283.33
NON-COVERD CHARGES	386,451.95	TOTAL MEDICAID LIAB	867,603.60
		LESS: COB	10,282.46
		LESS: COPAYMENT	1,749.00
		REIMBURSEMENT	855,572.14
		ALL OTHER	754,906.20
		FEE SCHEDULE-LAB	94,045.15
		INJECTABLE DRUGS	6,620.79

TOTAL NUMBER OF CLAIMS 2,361

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,954.46	4,859.00	OTHER LAB	48,574.00	0.00
MED/SURG SUPPLY	103,571.62	1,220.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	333.00	1,922.00
RADIOLOGY-DIAGNOSTIC	225,288.60	4,544.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	725,372.00	86,557.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,562.00	8,953.00	FEE SCHEDULE LAB	959,350.14	58,958.99
EKG/ECG	52,335.00	2,600.00	MRI SERVICES	61,156.00	6,293.00
IV THERAPY	192,752.00	91,142.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	251,425.50	25,554.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,581.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,126.25	9,711.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,265.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	62,028.00	10,632.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	917,639.00	7,995.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,742.00	23,717.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	106.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	769.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,324.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	140,389.00	12,812.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,203.00	1,022.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,667.00	20,487.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,044.00	1,166.00			
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	167,026.00	5,536.00			

TOTAL ANCILLARY	4,549,886.93	386,451.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,549,886.93	386,451.95

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,550.37	ADJUSTMENTS	0.00
COVERED CHARGES	52,171.57	CONTRACTUAL ALLOW	27,532.01
NON-COVERD CHARGES	12,378.80	TOTAL MEDICAID LIAB	24,639.56
		LESS: COB	24,632.33
		LESS: COPAYMENT	7.23
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,138.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,307.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,883.00	184.00	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	18,623.52	1,167.80
EKG/ECG	740.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,180.00	1,255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,911.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	399.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,889.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,479.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,890.00	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,696.00	1,340.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,661.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,906.00	2,094.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,166.00			
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	2,171.00	0.00			

TOTAL ANCILLARY	52,171.57	12,378.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,171.57	12,378.80

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	219,430.85	ADJUSTMENTS	5,842.46
COVERED CHARGES	205,648.85	CONTRACTUAL ALLOW	190,652.01
NON-COVERD CHARGES	13,782.00	TOTAL MEDICAID LIAB	14,996.84
		LESS: COB	649.50
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	13,951.34
		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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,387.00	157.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,943.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,643.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,062.00	6,454.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,613.00	2,257.00
EKG/ECG	1,783.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,556.00	3,690.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108.29	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	399.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,227.00	240.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,977.00	185.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	799.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	205,648.85	13,782.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,648.85	13,782.00

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,113.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,113.00	CONTRACTUAL ALLOW	4,053.73
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	59.27
		LESS: COB	56.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339.00	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	1,206.00	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	480.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,088.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,113.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,113.00	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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,310.14	ADJUSTMENTS	0.00
COVERED CHARGES	94,502.14	CONTRACTUAL ALLOW	84,589.32
NON-COVERD CHARGES	1,808.00	TOTAL MEDICAID LIAB	9,912.82
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	9,900.82
		TOTAL NUMBER OF CLAIMS	2

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

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,250.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,287.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	30.00	63.00
RADIOLOGY-DIAGNOSTIC	0.00	721.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,887.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,015.00	52.00
EKG/ECG	149.00	185.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,505.00	774.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,009.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,093.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,179.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,193.00	13.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	855.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,425.00	0.00			

TOTAL ANCILLARY	94,502.14	1,808.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,502.14	1,808.00

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

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	308,908.93	ADJUSTMENTS	16,799.16
COVERED CHARGES	286,035.93	CONTRACTUAL ALLOW	189,243.20
NON-COVERD CHARGES	22,873.00	TOTAL MEDICAID LIAB	96,792.73
		LESS: COB	9,993.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	86,799.57

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	88	0	39,487.00	22,199.00
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	88	0	39,487.00	22,199.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	4,620.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,620.00	0.00
TOTAL ACCOMODATIONS	92	0	44,107.00	22,199.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,472.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,663.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,803.00	0.00	EDUCATION & TRAINING	150.00	0.00
RADIOLOGY-DIAGNOSTIC	5,000.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,033.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	860.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,226.00	0.00	MRI SERVICES	2,675.00	0.00
IV THERAPY	1,245.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,839.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	609.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,864.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,452.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	788.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	688.00	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	2,875.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	485.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	592.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,375.00	674.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,886.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,794.00	0.00			

TOTAL ANCILLARY	241,928.93	674.00
TOTAL ACCOMODATIONS	44,107.00	22,199.00
TOTAL CHARGES	286,035.93	22,873.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	594,582.30	ADJUSTMENTS	48,897.15
COVERED CHARGES	533,177.85	CONTRACTUAL ALLOW	311,284.63
NON-COVERD CHARGES	61,404.45	TOTAL MEDICAID LIAB	221,893.22
		LESS: COB	905.28
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	220,441.94
		ALL OTHER	195,957.80
		FEE SCHEDULE-LAB	23,765.30
		INJECTABLE DRUGS	718.84

TOTAL NUMBER OF CLAIMS 794

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,990.73	25.40	OTHER LAB	3,418.00	0.00
MED/SURG SUPPLY	767.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,149.50	2,750.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,435.00	22,526.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,513.00	3,473.00	FEE SCHEDULE LAB	134,625.50	13,610.00
EKG/ECG	12,545.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,699.50	376.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	577.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	180,611.50	2,984.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,494.79	12,627.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,580.00	737.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,309.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	828.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,006.00	497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,128.00	970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,440.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,095.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,792.00	0.00			

TOTAL ANCILLARY	533,177.85	61,404.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	533,177.85	61,404.45

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	329.00	ADJUSTMENTS	0.00
COVERED CHARGES	319.00	CONTRACTUAL ALLOW	146.97
NON-COVERD CHARGES	10.00	TOTAL MEDICAID LIAB	172.03
		LESS: COB	172.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	319.00	10.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	319.00	10.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	319.00	10.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,480.19	ADJUSTMENTS	318.00
COVERED CHARGES	17,412.44	CONTRACTUAL ALLOW	15,292.44
NON-COVERD CHARGES	1,067.75	TOTAL MEDICAID LIAB	2,120.00
		LESS: COB	10.70
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	2,055.30
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332.44	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	544.00	402.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,783.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,498.00	198.00
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	13,124.00	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	131.00	467.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,412.44	1,067.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,412.44	1,067.75

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,068.25	ADJUSTMENTS	0.00
COVERED CHARGES	970.25	CONTRACTUAL ALLOW	469.54
NON-COVERD CHARGES	98.00	TOTAL MEDICAID LIAB	500.71
		LESS: COB	497.71
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.25	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	73.00	23.00
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	817.00	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	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	970.25	98.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	970.25	98.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

UNIVERSITY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,580,775.48	ADJUSTMENTS	0.00
COVERED CHARGES	1,580,775.48	CONTRACTUAL ALLOW	1,054,153.99
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	526,621.49
		LESS: COB	3,843.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	522,778.45

TOTAL NUMBER OF ADMISSIONS 61

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	144	0	83,520.00	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	144	0	83,520.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	95	0	92,435.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	95	0	92,435.00	0.00
TOTAL ACCOMODATIONS	239	0	175,955.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,930.13	0.00	OTHER LAB	690.00	0.00
MED/SURG SUPPLY	363,876.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	75,504.32	0.00	EDUCATION & TRAINING	397.00	0.00
RADIOLOGY-DIAGNOSTIC	18,902.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,287.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,837.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,812.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,186.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,998.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,174.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,887.10	0.00	INJECTABLE DRUGS	199.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,988.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	378.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	146,616.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,897.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,057.00	0.00			

TOTAL ANCILLARY	1,404,820.48	0.00
TOTAL ACCOMODATIONS	175,955.00	0.00
TOTAL CHARGES	1,580,775.48	0.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,364,483.18	ADJUSTMENTS	226,286.67
COVERED CHARGES	4,132,219.39	CONTRACTUAL ALLOW	3,384,649.58
NON-COVERD CHARGES	232,263.79	TOTAL MEDICAID LIAB	747,569.81
		LESS: COB	4,945.45
		LESS: COPAYMENT	1,446.00
		REIMBURSEMENT	741,178.36
		ALL OTHER	662,103.39
		FEE SCHEDULE-LAB	66,816.86
		INJECTABLE DRUGS	12,258.11

TOTAL NUMBER OF CLAIMS 2,049

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204,629.82	0.00	OTHER LAB	81,023.00	0.00
MED/SURG SUPPLY	293,635.01	34,785.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	537.00
RADIOLOGY-DIAGNOSTIC	203,272.00	247.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	606,417.00	61,186.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	459,191.68	19,103.32
EKG/ECG	86,803.00	1,572.00	MRI SERVICES	0.00	0.00
IV THERAPY	249,641.00	4,158.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	295,201.01	34,147.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,046.00	5,060.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,878.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,282,353.00	5,000.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,729.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	178,453.17	48,340.71
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,158.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,536.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,556.70	6,885.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,511.00	3,113.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,103.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,776.00	137.00			

TOTAL ANCILLARY	4,132,219.39	232,263.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,132,219.39	232,263.79

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,997.36	ADJUSTMENTS	0.00
COVERED CHARGES	29,684.62	CONTRACTUAL ALLOW	13,701.95
NON-COVERD CHARGES	8,312.74	TOTAL MEDICAID LIAB	15,982.67
		LESS: COB	15,967.67
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,944.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,264.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,136.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,208.60	80.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,575.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,430.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,920.00	513.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	920.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,980.27	153.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,079.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,684.62	8,312.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,684.62	8,312.74

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,856.61	ADJUSTMENTS	2,746.14
COVERED CHARGES	90,179.59	CONTRACTUAL ALLOW	83,377.07
NON-COVERD CHARGES	1,677.02	TOTAL MEDICAID LIAB	6,802.52
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	6,673.52
		TOTAL NUMBER OF CLAIMS	100

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,745.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,607.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,654.00	1,018.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,915.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,147.80	129.00
EKG/ECG	786.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,111.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,450.00	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	2,553.08	79.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	189.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	90,179.59	1,677.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,179.59	1,677.02

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,693.83	ADJUSTMENTS	0.00
COVERED CHARGES	2,673.83	CONTRACTUAL ALLOW	2,473.83
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	200.00
		LESS: COB	200.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	201.00	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	473.52	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	259.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	914.00	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	125.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,673.83	20.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,673.83	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,730,588.11	ADJUSTMENTS	1,122,134.87
COVERED CHARGES	43,101,238.60	CONTRACTUAL ALLOW	27,392,418.92
NON-COVERD CHARGES	1,629,349.51	TOTAL MEDICAID LIAB	15,708,819.68
		LESS: COB	217,336.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,491,483.67

TOTAL NUMBER OF ADMISSIONS 1,442

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,459	0	4,233,220.00	282,754.00
ROUTINE NURSERY	1,036	0	744,674.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,495	0	4,977,894.00	282,754.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,129	0	1,963,331.00	0.00
NICU	363	0	762,300.00	0.00
PED ICU	59	0	102,601.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,551	0	2,828,232.00	0.00
TOTAL ACCOMODATIONS	9,046	0	7,806,126.00	282,754.00

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,176,159.74	0.00	OTHER LAB	152,091.07	0.00
MED/SURG SUPPLY	3,276,748.52	1,670.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,377,577.72	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	859,423.62	0.00	OTHER THERAPEUTIC SVC	0.00	13,739.20
CT SCAN	1,391,269.34	580,829.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	329,533.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	194,070.08	0.00	MRI SERVICES	726,116.07	0.00
IV THERAPY	198,869.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,014,957.75	8,925.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	854,828.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,518,109.07	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,247.42	0.00	AMBULANCE	0.00	52,354.98
GI SERVICES	499,500.00	6,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,095,401.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	284,818.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	121,636.54	0.00	INJECTABLE DRUGS	6,710,556.21	0.00
RADIOLOGY THERAPEUTIC	237,026.47	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180,005.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	134,124.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	213,594.80	2,512.88	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,632.08	8,674.60	TRAUMA RESPONSE	0.00	19,200.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	996,370.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	507,440.19	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	831,858.78	623,204.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,169.38	28,984.91			
AUDIOLOGY	68,324.00	0.00			
CARDIOLOGY	899,087.02	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	84,931.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,633.96	0.00			

TOTAL ANCILLARY	35,295,112.60	1,346,595.51
TOTAL ACCOMODATIONS	7,806,126.00	282,754.00
TOTAL CHARGES	43,101,238.60	1,629,349.51

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	324,133.23	ADJUSTMENTS	0.00
COVERED CHARGES	309,406.90	CONTRACTUAL ALLOW	145,297.73
NON-COVERD CHARGES	14,726.33	TOTAL MEDICAID LIAB	164,109.17
		LESS: COB	164,109.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	21	0	13,776.00	930.00
ROUTINE NURSERY	48	0	39,280.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	69	0	53,056.50	930.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	21	0	44,100.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	44,100.00	0.00
TOTAL ACCOMODATIONS	90	0	97,156.50	930.00

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,259.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43,212.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,052.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,903.19	0.00	OTHER THERAPEUTIC SVC	0.00	226.24
CT SCAN	4,756.20	1,600.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	342.88	0.00	MRI SERVICES	6,089.92	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,052.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,420.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,812.62	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	974.80	0.00	AMBULANCE	0.00	3,077.29
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,682.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,590.30	0.00	INJECTABLE DRUGS	15,533.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	253.52	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.98	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,315.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,514.26	8,892.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	551.00	0.00			
CARDIOLOGY	1,570.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	218.64	0.00			

TOTAL ANCILLARY	212,250.40	13,796.33
TOTAL ACCOMODATIONS	97,156.50	930.00
TOTAL CHARGES	309,406.90	14,726.33

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,764,897.08	ADJUSTMENTS	813,825.02
COVERED CHARGES	18,358,409.08	CONTRACTUAL ALLOW	12,402,239.44
NON-COVERD CHARGES	3,406,488.00	TOTAL MEDICAID LIAB	5,956,169.64
		LESS: COB	13,621.41
		LESS: COPAYMENT	20,097.00
		REIMBURSEMENT	5,922,451.23
		ALL OTHER	5,037,371.38
		FEE SCHEDULE-LAB	298,911.17
		INJECTABLE DRUGS	586,168.68

TOTAL NUMBER OF CLAIMS 13,853

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230,054.97	2,871.15	OTHER LAB	72,540.75	0.00
MED/SURG SUPPLY	239,510.13	10,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	617,647.89	150,572.58	OTHER THERAPEUTIC SVC	0.00	7,996.40
CT SCAN	1,578,648.32	250,664.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,659.78	4,536.34	FEE SCHEDULE LAB	2,425,590.97	117,628.39
EKG/ECG	173,377.16	0.00	MRI SERVICES	267,879.28	14,870.16
IV THERAPY	1,353,229.80	65,328.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	591,177.97	391,754.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,207.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177,537.17	9,277.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,997.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	450,500.00	97,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,132,687.32	35,513.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	269,712.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,102,194.98	1,560,062.87
RADIOLOGY THERAPEUTIC	1,017,571.16	320,129.51	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,385.32	1,057.56	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,570.59	8,008.17	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	628.22	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	474,365.85	85,036.18	TRAUMA RESPONSE	0.00	6,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,432.57	12,336.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,691.00
OTHER IMAGING SERVICE	458,240.44	50,990.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	110,751.00	85,622.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,247.08	63,961.28			
AUDIOLOGY	61.00	551.00			
CARDIOLOGY	95,636.00	46,539.80			
AMBULATORY SURGERY	6,869.68	462.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,101.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	150,022.92	4,739.73			

TOTAL ANCILLARY	18,358,409.08	3,406,488.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,358,409.08	3,406,488.00

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	5918151002210	04/09/18 - 04/09/18	06/04/18	0.00	1,691.00	0.00	0.00	0.00
TOTAL				0.00	1,691.00	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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	379,176.30	ADJUSTMENTS	0.00
COVERED CHARGES	217,235.25	CONTRACTUAL ALLOW	78,731.86
NON-COVERD CHARGES	161,941.05	TOTAL MEDICAID LIAB	138,503.39
		LESS: COB	138,312.82
		LESS: COPAYMENT	190.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 149

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,181.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,097.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,052.34	3,071.00	OTHER THERAPEUTIC SVC	0.00	2,518.00
CT SCAN	4,107.80	14,472.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,756.98	3,862.21
EKG/ECG	685.76	0.00	MRI SERVICES	0.00	2,978.13
IV THERAPY	23,031.30	203.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,485.34	4,970.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,071.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,464.48	228.48	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,383.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,500.00	15,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,314.50	1,656.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,927.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,040.22	95,773.09
RADIOLOGY THERAPEUTIC	21,794.41	6,250.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	150.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	224.40	2,017.30	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,163.48	6,885.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,236.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	905.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,949.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,767.13	1,001.36			

TOTAL ANCILLARY	217,235.25	161,941.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,235.25	161,941.05

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	459,207.44	ADJUSTMENTS	768.16
COVERED CHARGES	440,222.87	CONTRACTUAL ALLOW	405,596.01
NON-COVERD CHARGES	18,984.57	TOTAL MEDICAID LIAB	34,626.86
		LESS: COB	34.40
		LESS: COPAYMENT	681.00
		REIMBURSEMENT	33,911.46
		TOTAL NUMBER OF CLAIMS	619

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,401.40	0.00	OTHER LAB	451.00	0.00
MED/SURG SUPPLY	325.54	254.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,830.91	5,136.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,084.15	2,585.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,071.56	1,400.91
EKG/ECG	4,286.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,647.00	406.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,318.00	351.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	188.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,692.10	414.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,487.45	3,720.50
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	135.04	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,290.34	1,676.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,120.75	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,372.75	682.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	655.92	0.00			

TOTAL ANCILLARY	440,222.87	18,984.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	440,222.87	18,984.57

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,102.94	ADJUSTMENTS	0.00
COVERED CHARGES	21,780.44	CONTRACTUAL ALLOW	15,483.29
NON-COVERD CHARGES	1,322.50	TOTAL MEDICAID LIAB	6,297.15
		LESS: COB	6,291.15
		LESS: COPAYMENT	6.00
		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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	277.00	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	3,337.35	126.91
EKG/ECG	342.88	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,592.87	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	353.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,213.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,548.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	805.15	207.65
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	539.00	987.94			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	380.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,780.44	1,322.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,780.44	1,322.50

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,184,654.55	ADJUSTMENTS	98,353.26
COVERED CHARGES	1,916,348.98	CONTRACTUAL ALLOW	1,372,741.44
NON-COVERD CHARGES	268,305.57	TOTAL MEDICAID LIAB	543,607.54
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	543,325.54
		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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,711.91	249.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110,614.14	573.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,261.33	32,567.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,632.55	5,170.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	578.14	FEE SCHEDULE LAB	20,933.38	1,373.31
EKG/ECG	1,371.52	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	52,112.70	406.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	372,292.96	42,699.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,699.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,972.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,492.60	828.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,205.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	678,176.73	55,700.96
RADIOLOGY THERAPEUTIC	72,262.49	500.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,268.32	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	360,588.20	107,416.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,340.57	1,481.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,628.25	3,672.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,211.04			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	707.30	8,610.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,345.47	0.00			

TOTAL ANCILLARY	1,916,348.98	268,305.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,916,348.98	268,305.57

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,295,093.56	ADJUSTMENTS	1,854,006.87
COVERED CHARGES	154,776,555.30	CONTRACTUAL ALLOW	118,420,146.86
NON-COVERD CHARGES	5,518,538.26	TOTAL MEDICAID LIAB	36,356,408.44
		LESS: COB	497,056.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,859,351.70

TOTAL NUMBER OF ADMISSIONS 2,596

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13,527	0	11,953,435.00	638,408.00
ROUTINE NURSERY	2,203	0	6,893,947.00	483,626.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15,730	0	18,847,382.00	1,122,034.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,946	0	11,030,593.00	253,873.00
NICU	164	0	1,002,035.00	0.00
PED ICU	1,144	0	3,774,711.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,254	0	15,807,339.00	253,873.00
TOTAL ACCOMODATIONS	20,984	0	34,654,721.00	1,375,907.00

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,754,571.11	396,592.02	OTHER LAB	857,115.00	13,494.00
MED/SURG SUPPLY	5,076,712.50	166,348.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,171,639.36	252,826.00	EDUCATION & TRAINING	89.00	0.00
RADIOLOGY-DIAGNOSTIC	3,549,171.00	30,916.00	OTHER THERAPEUTIC SVC	0.00	288,449.00
CT SCAN	6,361,957.00	159,812.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	850,892.10	13,162.18	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	553,909.00	2,491.00	MRI SERVICES	2,109,695.00	11,455.00
IV THERAPY	591,839.00	2,703.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,888,833.02	76,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,206,750.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,411,619.00	341,013.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,727,910.00	1,198.00	AMBULANCE	0.00	0.00
GI SERVICES	16,542.00	4,027.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,996,154.00	2,483.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,126,084.00	1,478.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	211,635.00	418.00	INJECTABLE DRUGS	8,168,103.96	157,854.86
RADIOLOGY THERAPEUTIC	22,867.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	306,203.65	2,498.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	278,855.27	5,143.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,270,777.00	1,907,863.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,077.00	44,395.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	45,633.00	0.00	IMPL DEV CHARGE PATIENTS	6,916,435.33	8,021.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	354.00
OTHER IMAGING SERVICE	426,504.00	3,774.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,896,175.00	83,134.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	569,532.00	68,400.00			
AUDIOLOGY	0.00	27,308.00			
CARDIOLOGY	3,945,335.00	8,737.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	198,777.00	3,609.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,612,442.00	56,304.00			

TOTAL ANCILLARY	120,121,834.30	4,142,631.26
TOTAL ACCOMODATIONS	34,654,721.00	1,375,907.00
TOTAL CHARGES	154,776,555.30	5,518,538.26

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2018169012970	12/23/17 - 12/28/17	06/25/18	0.00	354.00	0.00	0.00	0.00
TOTAL				0.00	354.00	0.00	0.00	0.00

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,138,604.31	ADJUSTMENTS	0.00
COVERED CHARGES	2,056,447.31	CONTRACTUAL ALLOW	506,425.19
NON-COVERD CHARGES	82,157.00	TOTAL MEDICAID LIAB	1,550,022.12
		LESS: COB	1,550,022.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	67	0	60,721.00	1,400.00
ROUTINE NURSERY	280	0	879,139.00	73,988.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	347	0	939,860.00	75,388.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	11	0	31,486.00	0.00
NICU	6	0	35,310.00	0.00
PED ICU	3	0	9,906.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	76,702.00	0.00
TOTAL ACCOMODATIONS	367	0	1,016,562.00	75,388.00

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	185,066.48	0.00	OTHER LAB	5,478.00	0.00
MED/SURG SUPPLY	69,209.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	144,790.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,841.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,050.00
CT SCAN	14,899.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,003.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,496.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,790.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,490.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	66,541.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	179,918.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,934.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,882.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,063.00	0.00	INJECTABLE DRUGS	30,754.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,879.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,014.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,292.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	211.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,476.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,314.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,498.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,916.00	865.00			
AUDIOLOGY	0.00	1,351.00			
CARDIOLOGY	39,808.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,491.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,964.00	0.00			

TOTAL ANCILLARY	1,039,885.31	6,769.00
TOTAL ACCOMODATIONS	1,016,562.00	75,388.00
TOTAL CHARGES	2,056,447.31	82,157.00

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,652,743.24	ADJUSTMENTS	1,262,304.87
COVERED CHARGES	45,731,207.12	CONTRACTUAL ALLOW	36,320,086.69
NON-COVERD CHARGES	6,921,536.12	TOTAL MEDICAID LIAB	9,411,120.43
		LESS: COB	46,213.54
		LESS: COPAYMENT	24,893.58
		REIMBURSEMENT	9,340,013.31
		ALL OTHER	7,756,574.67
		FEE SCHEDULE-LAB	887,992.62
		INJECTABLE DRUGS	695,446.02

TOTAL NUMBER OF CLAIMS 22,599

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,087,153.83	23,208.11	OTHER LAB	358,319.00	8,518.00
MED/SURG SUPPLY	740,916.00	77,676.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,136,389.00	145,432.00	OTHER THERAPEUTIC SVC	0.00	496.00
CT SCAN	3,852,383.00	691,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,678.00	24,256.36	FEE SCHEDULE LAB	9,716,039.16	416,517.71
EKG/ECG	385,997.00	9,164.00	MRI SERVICES	40,536.00	135,341.00
IV THERAPY	1,654,966.00	247,478.00	PROFESSIONAL FEES	0.00	84.00
OPERATING ROOM	4,764,185.25	973,487.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	128,655.00	51,450.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	269,126.00	85,557.00	FREE STANDING CLINIC	0.00	108.00
ANESTHESIA	1,202,055.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	90,932.67	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,334,065.84	79,608.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,486,604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,710,031.37	1,084,775.34
RADIOLOGY THERAPEUTIC	213,181.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,792.00	9,983.54	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,474.00	8,774.45	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	94,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,944,644.00	318,029.37	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	180,053.00	1,669,648.00
LITHOTRIPSY	10,021.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	465,236.00	71,581.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	453,486.00	912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	536,665.00	125,841.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	437,820.00	311,713.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	153,957.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,246,846.00	255,130.00			

TOTAL ANCILLARY	45,731,207.12	6,921,536.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,731,207.12	6,921,536.12

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,087,754.92	ADJUSTMENTS	0.00
COVERED CHARGES	715,853.81	CONTRACTUAL ALLOW	288,969.93
NON-COVERD CHARGES	371,901.11	TOTAL MEDICAID LIAB	426,883.88
		LESS: COB	426,689.53
		LESS: COPAYMENT	194.35
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	286

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,851.17	16,789.97	OTHER LAB	1,770.00	0.00
MED/SURG SUPPLY	12,600.00	240.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,005.00	3,014.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,254.00	31,703.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,204.04	FEE SCHEDULE LAB	83,080.00	5,552.00
EKG/ECG	3,407.00	0.00	MRI SERVICES	4,628.00	19,836.00
IV THERAPY	24,880.00	4,108.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,387.40	81,323.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,974.00	3,868.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,790.00	2,004.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,347.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,069.00	93.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,281.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119,013.24	19,787.50
RADIOLOGY THERAPEUTIC	10,676.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	430.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,254.00	627.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,325.00	6,522.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,333.00	148,290.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,132.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,165.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,471.00	268.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	534.00	5,674.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,209.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,472.00	20,567.00			

TOTAL ANCILLARY	715,853.81	371,901.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	715,853.81	371,901.11

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	819,333.50	ADJUSTMENTS	7,500.13
COVERED CHARGES	786,893.27	CONTRACTUAL ALLOW	753,429.68
NON-COVERD CHARGES	32,440.23	TOTAL MEDICAID LIAB	33,463.59
		LESS: COB	44.74
		LESS: COPAYMENT	1,020.00
		REIMBURSEMENT	32,398.85

TOTAL NUMBER OF CLAIMS 570

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,356.72	38.47	OTHER LAB	984.00	0.00
MED/SURG SUPPLY	535.00	274.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,462.00	8,089.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,113.00	10,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	180,445.00	7,249.00
EKG/ECG	8,392.00	192.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,899.00	558.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,990.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,716.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,628.00	1,089.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,856.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,164.55	1,292.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	627.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	428.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,143.00	702.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,862.00	1,379.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,919.00	0.00			

TOTAL ANCILLARY	786,893.27	32,440.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	786,893.27	32,440.23

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,362.19	ADJUSTMENTS	0.00
COVERED CHARGES	22,182.50	CONTRACTUAL ALLOW	8,117.57
NON-COVERD CHARGES	7,179.69	TOTAL MEDICAID LIAB	14,064.93
		LESS: COB	14,040.93
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.71	208.69	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	838.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,663.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,713.00	308.00
EKG/ECG	185.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,018.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,320.00	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	38.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,182.50	7,179.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,182.50	7,179.69

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,607,613.58	ADJUSTMENTS	138,731.30
COVERED CHARGES	10,805,776.86	CONTRACTUAL ALLOW	9,050,599.31
NON-COVERD CHARGES	1,801,836.72	TOTAL MEDICAID LIAB	1,755,177.55
		LESS: COB	0.00
		LESS: COPAYMENT	807.58
		REIMBURSEMENT	1,754,369.97

TOTAL NUMBER OF CLAIMS 291

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,871.80	3,588.77	OTHER LAB	44,482.00	3,646.00
MED/SURG SUPPLY	457,938.00	343,019.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	106,075.00	181,598.00	OTHER THERAPEUTIC SVC	0.00	51.00
CT SCAN	115,828.00	34,737.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	667.00	8,591.28	FEE SCHEDULE LAB	239,549.00	9,536.00
EKG/ECG	22,317.00	2,084.00	MRI SERVICES	19,154.00	6,205.00
IV THERAPY	63,343.00	20,187.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,315,545.90	125,096.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,934.00	6,206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,831.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,790.75	7,380.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,391.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,980,907.41	89,284.13
RADIOLOGY THERAPEUTIC	75,875.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	567.00	3,667.14	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	892.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,783.00	3,665.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	899,027.00	662,940.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,326.00	3,974.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,249.00	912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,573.00	22,074.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	373,137.00	109,119.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	855.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,374,760.00	153,384.00			

TOTAL ANCILLARY	10,805,776.86	1,801,836.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,805,776.86	1,801,836.72

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	270,448.42	ADJUSTMENTS	56,372.47
COVERED CHARGES	270,448.42	CONTRACTUAL ALLOW	100,426.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	170,022.42
		LESS: COB	904.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	169,117.51

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	23,040.00	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	72	0	23,040.00	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	72	0	23,040.00	0.00

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,723.72	0.00	OTHER LAB	2,047.00	0.00
MED/SURG SUPPLY	7,924.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,193.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,088.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,637.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,020.00	0.00	MRI SERVICES	1,164.00	0.00
IV THERAPY	1,220.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,984.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,228.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,362.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,595.00	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	250.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,173.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,374.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,482.00	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	2,406.00	0.00			

TOTAL ANCILLARY	247,408.42	0.00
TOTAL ACCOMODATIONS	23,040.00	0.00
TOTAL CHARGES	270,448.42	0.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,707,654.32	ADJUSTMENTS	134,604.28
COVERED CHARGES	1,675,401.35	CONTRACTUAL ALLOW	1,176,870.07
NON-COVERD CHARGES	32,252.97	TOTAL MEDICAID LIAB	498,531.28
		LESS: COB	1,254.20
		LESS: COPAYMENT	1,272.00
		REIMBURSEMENT	496,005.08
		ALL OTHER	455,516.33
		FEE SCHEDULE-LAB	37,746.59
		INJECTABLE DRUGS	2,742.16

TOTAL NUMBER OF CLAIMS 1,186

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,209.53	26.45	OTHER LAB	13,835.00	0.00
MED/SURG SUPPLY	28,770.40	201.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	539.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,693.00	2,366.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,802.00	6,670.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,008.00	3,573.02	FEE SCHEDULE LAB	242,347.45	2,599.00
EKG/ECG	43,076.00	170.00	MRI SERVICES	28,012.00	0.00
IV THERAPY	102,035.00	952.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,302.00	2,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,463.00	1,322.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,203.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	491,883.00	1,184.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,300.97	1,938.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,552.00	1,668.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	597.00	1,065.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,342.00	1,834.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,395.00	713.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	42,613.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	41,051.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,055.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	85,856.00	2,818.00			

TOTAL ANCILLARY	1,675,401.35	32,252.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,675,401.35	32,252.97

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,681.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,860.00	CONTRACTUAL ALLOW	1,143.11
NON-COVERD CHARGES	821.00	TOTAL MEDICAID LIAB	1,716.89
		LESS: COB	1,707.89
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	934.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	758.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	532.00	63.00
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	1,394.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,860.00	821.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,860.00	821.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,329.95	ADJUSTMENTS	2,652.16
COVERED CHARGES	160,708.20	CONTRACTUAL ALLOW	150,482.08
NON-COVERD CHARGES	2,621.75	TOTAL MEDICAID LIAB	10,226.12
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	9,857.12
		TOTAL NUMBER OF CLAIMS	172

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,375.30	14.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	454.50	70.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,467.00	290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,901.00	1,516.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,242.00	372.00
EKG/ECG	2,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,174.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	312.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,199.00	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	1,559.40	359.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	160,708.20	2,621.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	160,708.20	2,621.75

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,662.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,533.00	CONTRACTUAL ALLOW	657.00
NON-COVERD CHARGES	129.30	TOTAL MEDICAID LIAB	876.00
		LESS: COB	873.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	26.00	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	1,507.00	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	129.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,533.00	129.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,533.00	129.30

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,484.87	ADJUSTMENTS	5,545.23
COVERED CHARGES	39,446.17	CONTRACTUAL ALLOW	28,355.71
NON-COVERD CHARGES	38.70	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,090.46

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	404.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	355.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,124.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,114.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,632.00	21.00
EKG/ECG	850.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	683.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,955.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,190.60	17.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	322.00	0.00			

TOTAL ANCILLARY	39,446.17	38.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,446.17	38.70

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,937,345.85	ADJUSTMENTS	1,816,019.04
COVERED CHARGES	26,456,497.06	CONTRACTUAL ALLOW	19,802,570.02
NON-COVERD CHARGES	2,480,848.79	TOTAL MEDICAID LIAB	6,653,927.04
		LESS: COB	2,548.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,651,378.62

TOTAL NUMBER OF ADMISSIONS 632

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,024	0	1,837,603.40	1,427,622.64
ROUTINE NURSERY	76	0	67,610.00	15,710.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	534,105.15
TOTAL ROUTINE	2,100	0	1,905,213.40	1,977,437.79
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	926	0	2,484,227.00	24,960.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	926	0	2,484,227.00	24,960.00
TOTAL ACCOMODATIONS	3,026	0	4,389,440.40	2,002,397.79

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464,929.65	563.00	OTHER LAB	116,528.00	0.00
MED/SURG SUPPLY	896,518.24	13,051.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,183,599.00	5,100.00	EDUCATION & TRAINING	12,266.00	284.00
RADIOLOGY-DIAGNOSTIC	459,183.65	738.00	OTHER THERAPEUTIC SVC	0.00	23,876.00
CT SCAN	1,085,282.00	57,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	216,857.00	1,336.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	229,082.00	397.00	MRI SERVICES	181,061.00	0.00
IV THERAPY	132,139.00	1,664.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,180,107.00	14,978.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	117,965.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,715,469.30	103,125.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	612,346.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	326,856.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,753,606.50	5,474.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	84,955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	131,278.00	0.00	INJECTABLE DRUGS	3,346,163.32	8,379.00
RADIOLOGY THERAPEUTIC	13,138.00	3,594.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	85,188.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,259.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	252,066.00	12,804.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,342.00	3,770.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	211,150.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	240,453.00	16,062.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	231,350.00	193,533.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,992.00	12,353.00			
AUDIOLOGY	6,480.00	0.00			
CARDIOLOGY	1,442,437.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,941.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	159,069.00	0.00			

TOTAL ANCILLARY	22,067,056.66	478,451.00
TOTAL ACCOMODATIONS	4,389,440.40	2,002,397.79
TOTAL CHARGES	26,456,497.06	2,480,848.79

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 01/01/18 THROUGH 12/31/18
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	2019029079980	11/26/18 - 12/11/18	02/04/19	0.00	0.00	0.00	0.00	0.00
24	2019100071355	08/08/18 - 08/22/18	04/15/19	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,852,308.74	ADJUSTMENTS	104,618.57
COVERED CHARGES	16,770,292.15	CONTRACTUAL ALLOW	13,657,631.28
NON-COVERD CHARGES	2,082,016.59	TOTAL MEDICAID LIAB	3,112,660.87
		LESS: COB	1,470.85
		LESS: COPAYMENT	7,299.48
		REIMBURSEMENT	3,103,890.54
		ALL OTHER	2,900,805.16
		FEE SCHEDULE-LAB	176,107.12
		INJECTABLE DRUGS	26,978.26

TOTAL NUMBER OF CLAIMS 6,153

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285,233.99	19,837.00	OTHER LAB	148,622.00	0.00
MED/SURG SUPPLY	259,937.85	6,523.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,584.00
RADIOLOGY-DIAGNOSTIC	824,508.90	29,486.00	OTHER THERAPEUTIC SVC	0.00	2,224.00
CT SCAN	1,464,329.50	290,908.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,542.00	5,614.00	FEE SCHEDULE LAB	1,822,890.45	185,443.77
EKG/ECG	248,014.00	1,205.00	MRI SERVICES	431,680.00	44,909.00
IV THERAPY	1,439,917.00	84,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,148,353.33	191,662.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	726.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,524.48	5,416.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	728,365.00	757.00	AMBULANCE	0.00	0.00
GI SERVICES	809,298.00	104,588.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,785,179.37	49,822.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	158,003.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	246,403.00	182,849.00
RADIOLOGY THERAPEUTIC	99,037.00	117,951.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,186.00	3,688.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	852.00	1,849.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,769.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,435.00	36,072.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,264.44	12,135.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	990,465.00	173,254.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,078.00	19,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	282,047.00	304,148.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	421,997.00	164,409.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	405,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215,512.84	30,372.00			

TOTAL ANCILLARY	16,770,292.15	2,082,016.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,770,292.15	2,082,016.59

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,949.80	ADJUSTMENTS	0.00
COVERED CHARGES	89,333.80	CONTRACTUAL ALLOW	22,358.99
NON-COVERD CHARGES	95,616.00	TOTAL MEDICAID LIAB	66,974.81
		LESS: COB	66,927.52
		LESS: COPAYMENT	47.29
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,162.00	292.00	OTHER LAB	779.00	0.00
MED/SURG SUPPLY	1,178.80	231.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,029.00	369.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,676.00	9,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,435.00	647.00
EKG/ECG	728.00	0.00	MRI SERVICES	0.00	2,789.00
IV THERAPY	10,641.00	554.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	12,258.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,727.00	1,464.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,811.00	2,957.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	882.00	57,683.00
RADIOLOGY THERAPEUTIC	1,117.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,641.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,948.00	2,953.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,051.00	0.00			

TOTAL ANCILLARY	89,333.80	95,616.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	89,333.80	95,616.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,730,820.36	ADJUSTMENTS	16,327.66
COVERED CHARGES	1,582,207.64	CONTRACTUAL ALLOW	1,530,484.12
NON-COVERD CHARGES	148,612.72	TOTAL MEDICAID LIAB	51,723.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,584.00
		REIMBURSEMENT	50,139.52

TOTAL NUMBER OF CLAIMS 785

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,222.00	2,311.00	OTHER LAB	14,148.00	0.00
MED/SURG SUPPLY	3,755.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,750.24	11,528.72	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	135,902.00	107,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	175,148.00	5,820.00
EKG/ECG	16,482.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	91,619.00	790.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,707.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,817.00	1,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,920.00	2,934.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,377.00	16,314.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,360.00	688.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,582,207.64	148,612.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,582,207.64	148,612.72

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,064.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,908.00	CONTRACTUAL ALLOW	3,207.76
NON-COVERD CHARGES	156.00	TOTAL MEDICAID LIAB	1,700.24
		LESS: COB	1,697.24
		LESS: COPAYMENT	3.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	156.00	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	295.00	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	325.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,175.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	113.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,908.00	156.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,908.00	156.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,052,549.97	ADJUSTMENTS	0.00
COVERED CHARGES	1,016,291.47	CONTRACTUAL ALLOW	873,787.72
NON-COVERD CHARGES	36,258.50	TOTAL MEDICAID LIAB	142,503.75
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	142,425.75
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,619.00	172.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,927.97	635.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,617.00	1,437.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,706.00	3,179.00
EKG/ECG	993.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,079.00	247.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,514.50	3,417.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	794.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,928.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,058.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	712,705.00	26,235.00
RADIOLOGY THERAPEUTIC	3,674.00	936.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	2,697.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,290.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,924.00	0.00			

TOTAL ANCILLARY	1,016,291.47	36,258.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,016,291.47	36,258.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	384,013.64	ADJUSTMENTS	6,554.14
COVERED CHARGES	335,333.64	CONTRACTUAL ALLOW	200,217.76
NON-COVERD CHARGES	48,680.00	TOTAL MEDICAID LIAB	135,115.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	135,115.88

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	128	0	120,320.00	48,680.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	128	0	120,320.00	48,680.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,640.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	3,640.00	0.00
TOTAL ACCOMODATIONS	130	0	123,960.00	48,680.00

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,249.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,607.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,321.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,216.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,645.41	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,015.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,992.72	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	2,871.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,190.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	124.38	0.00	INJECTABLE DRUGS	86,896.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,228.32	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,934.18	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,725.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	459.46	0.00			

TOTAL ANCILLARY	211,373.64	0.00
TOTAL ACCOMODATIONS	123,960.00	48,680.00
TOTAL CHARGES	335,333.64	48,680.00

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	515,361.06	ADJUSTMENTS	13,344.26
COVERED CHARGES	461,844.13	CONTRACTUAL ALLOW	389,021.75
NON-COVERD CHARGES	53,516.93	TOTAL MEDICAID LIAB	72,822.38
		LESS: COB	31.95
		LESS: COPAYMENT	579.00
		REIMBURSEMENT	72,211.43
		ALL OTHER	51,589.34
		FEE SCHEDULE-LAB	20,508.33
		INJECTABLE DRUGS	113.76

TOTAL NUMBER OF CLAIMS 644

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,104.58	0.00	OTHER LAB	44,226.56	0.00
MED/SURG SUPPLY	3,714.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,897.43	885.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,179.03	27,257.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,533.28	3,492.67	FEE SCHEDULE LAB	166,468.29	7,323.49
EKG/ECG	3,187.05	249.09	MRI SERVICES	0.00	0.00
IV THERAPY	9,272.87	2,888.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,523.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	574.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,470.03	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,400.00	1,200.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,235.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,006.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,756.72	1,676.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	438.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,163.63	474.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,835.45	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,351.62	5,450.54			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,943.64	2,180.10			

TOTAL ANCILLARY	461,844.13	53,516.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	461,844.13	53,516.93

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,193.48	ADJUSTMENTS	0.00
COVERED CHARGES	10,478.64	CONTRACTUAL ALLOW	4,922.56
NON-COVERD CHARGES	1,714.84	TOTAL MEDICAID LIAB	5,556.08
		LESS: COB	5,535.08
		LESS: COPAYMENT	21.00
		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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,244.09	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	2,136.66	481.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.44	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	472.86	0.00	FREE STANDING CLINIC	0.00	0.00
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	593.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,212.44	869.74			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,115.45	363.35			

TOTAL ANCILLARY	10,478.64	1,714.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,478.64	1,714.84

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,093,036.03	ADJUSTMENTS	64,271.24
COVERED CHARGES	2,890,314.03	CONTRACTUAL ALLOW	1,871,950.82
NON-COVERD CHARGES	202,722.00	TOTAL MEDICAID LIAB	1,018,363.21
		LESS: COB	15,330.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,003,032.30

TOTAL NUMBER OF ADMISSIONS 165

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	399	0	264,210.00	118,865.00
ROUTINE NURSERY	55	0	30,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	454	0	295,010.00	118,865.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	142	0	186,020.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	142	0	186,020.00	0.00
TOTAL ACCOMODATIONS	596	0	481,030.00	118,865.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343,988.20	0.00	OTHER LAB	19,739.00	0.00
MED/SURG SUPPLY	187,949.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	507,395.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,601.00	0.00	OTHER THERAPEUTIC SVC	219.00	0.00
CT SCAN	159,896.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,146.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,254.00	0.00	MRI SERVICES	26,878.00	0.00
IV THERAPY	59,948.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,847.00	51,099.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	176,419.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	307,265.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,719.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,327.00	0.00	SPECIAL SERVICES	0.00	771.00
RECOVERY ROOM	18,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,673.00	0.00	INJECTABLE DRUGS	1,366.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,332.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	887.04	1,019.00	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	NO CC/INVALID REV CODE	0.00	2,648.00
OTHER IMAGING SERVICE	6,006.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,541.00	28,320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,984.00	0.00			
AUDIOLOGY	9,636.00	0.00			
CARDIOLOGY	22,544.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,189.00	0.00			

TOTAL ANCILLARY	2,409,284.03	83,857.00
TOTAL ACCOMODATIONS	481,030.00	118,865.00
TOTAL CHARGES	2,890,314.03	202,722.00

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 04/01/17 THROUGH 03/31/18
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
31	2217283002161	09/26/17 - 09/28/17	10/16/17	0.00	110.00	0.00	0.00	0.00
615	2218003001693	07/21/17 - 07/24/17	01/08/18	0.00	2,434.00	0.00	0.00	0.00
308	2218024004195	12/18/17 - 12/20/17	01/29/18	0.00	104.00	0.00	0.00	0.00
TOTAL				0.00	2,648.00	0.00	0.00	0.00

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

MEMORIAL 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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,568.50	ADJUSTMENTS	0.00
COVERED CHARGES	8,568.50	CONTRACTUAL ALLOW	2,942.86
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,625.64
		LESS: COB	5,625.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	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	2	0	2,620.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	2,620.00	0.00
TOTAL ACCOMODATIONS	2	0	2,620.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	850.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,828.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,876.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	308.00	0.00			

TOTAL ANCILLARY	5,948.50	0.00
TOTAL ACCOMODATIONS	2,620.00	0.00
TOTAL CHARGES	8,568.50	0.00

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,153,519.19	ADJUSTMENTS	186,619.00
COVERED CHARGES	4,733,322.18	CONTRACTUAL ALLOW	3,765,026.57
NON-COVERD CHARGES	420,197.01	TOTAL MEDICAID LIAB	968,295.61
		LESS: COB	3,398.95
		LESS: COPAYMENT	2,292.42
		REIMBURSEMENT	962,604.24
		ALL OTHER	813,877.90
		FEE SCHEDULE-LAB	143,927.31
		INJECTABLE DRUGS	4,799.03

TOTAL NUMBER OF CLAIMS 3,053

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,336.90	9,147.65	OTHER LAB	94,948.00	475.00
MED/SURG SUPPLY	172,076.40	2,185.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,471.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,119.00	10,184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	626,460.00	91,956.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,015.00	8,735.00	FEE SCHEDULE LAB	1,126,833.00	64,289.00
EKG/ECG	66,064.00	6,408.00	MRI SERVICES	67,496.00	16,936.00
IV THERAPY	258,014.00	29,129.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	351,624.00	33,991.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,359.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,115.00	69,200.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,028.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,150,975.00	8,908.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,705.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	119.00	INJECTABLE DRUGS	17,460.03	9,140.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,118.00	3,441.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,314.00	417.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,736.00	4,219.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,963.00	3,578.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,295.10
OTHER IMAGING SERVICE	72,108.00	7,556.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,964.00	11,800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,654.00	1,240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,045.00	5,636.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,791.00	10,741.00			

TOTAL ANCILLARY	4,733,322.18	420,197.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,733,322.18	420,197.01

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	5917207000708	05/04/17 - 05/04/17	07/31/17	0.00	2,918.00	0.00	0.00	0.00
616	5917207000708	05/04/17 - 05/04/17	07/31/17	0.00	1,946.00	0.00	0.00	0.00
615	2017215083023	07/24/17 - 07/24/17	08/07/17	0.00	1,217.00	0.00	0.00	0.00
615	2017215083023	07/24/17 - 07/24/17	08/07/17	0.00	1,946.00	0.00	0.00	0.00
3017	2217272002858	09/05/17 - 09/05/17	10/02/17	0.00	48.00	0.00	0.00	0.00
615	5918010002275	10/24/17 - 10/24/17	01/15/18	0.00	1,217.00	0.00	0.00	0.00
2500	2218239007572	11/19/17 - 11/19/17	09/03/18	0.00	3.10	0.00	0.00	0.00
TOTAL				0.00	9,295.10	0.00	0.00	0.00

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

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,127.55	ADJUSTMENTS	0.00
COVERED CHARGES	48,362.55	CONTRACTUAL ALLOW	25,932.17
NON-COVERD CHARGES	3,765.00	TOTAL MEDICAID LIAB	22,430.38
		LESS: COB	22,364.38
		LESS: COPAYMENT	66.00
		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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,173.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,468.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,074.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,862.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,847.00	2,244.00	FEE SCHEDULE LAB	9,561.00	140.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,718.00	576.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,865.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	169.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,926.00	143.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,278.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	206.50	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	618.00	143.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	48,362.55	3,765.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,362.55	3,765.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	186,919.20	ADJUSTMENTS	538.40
COVERED CHARGES	177,445.70	CONTRACTUAL ALLOW	167,488.38
NON-COVERD CHARGES	9,473.50	TOTAL MEDICAID LIAB	9,957.32
		LESS: COB	46.02
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	9,614.30
		TOTAL NUMBER OF CLAIMS	178

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,017.40	28.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,246.00	416.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,753.00	490.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,983.00	3,731.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,678.00	2,876.00
EKG/ECG	1,081.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,511.00	312.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,131.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,213.00	805.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	313.30	153.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	143.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	519.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,445.70	9,473.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,445.70	9,473.50

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	138,900,749.04	ADJUSTMENTS	1,284,343.31
COVERED CHARGES	129,084,242.29	CONTRACTUAL ALLOW	93,860,212.44
NON-COVERD CHARGES	9,816,506.75	TOTAL MEDICAID LIAB	35,224,029.85
		LESS: COB	178,390.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,045,639.30

TOTAL NUMBER OF ADMISSIONS 2,734

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,847	0	12,032,510.40	6,683,326.68
ROUTINE NURSERY	2,055	0	4,645,041.75	518,029.75
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	434,905.81
TOTAL ROUTINE	14,902	0	16,677,552.15	7,636,262.24
SPECIAL CARE SERVICES				
CCU	243	0	1,013,183.25	0.00
ICU	3,894	0	10,501,811.50	0.00
NICU	135	0	591,775.50	0.00
PED ICU	495	0	2,703,049.50	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	357	0	1,678,719.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,124	0	16,488,538.75	0.00
TOTAL ACCOMODATIONS	20,026	0	33,166,090.90	7,636,262.24

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,422,502.49	105.59	OTHER LAB	536,744.22	0.00
MED/SURG SUPPLY	8,110,786.45	4,565.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,320,442.85	2,393.04	EDUCATION & TRAINING	19,653.12	0.00
RADIOLOGY-DIAGNOSTIC	3,123,098.57	0.00	OTHER THERAPEUTIC SVC	0.00	1,677.56
CT SCAN	2,712,699.21	578,580.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,193,650.76	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	452,703.58	0.00	MRI SERVICES	1,174,325.19	0.00
IV THERAPY	748,773.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,913,557.99	124,185.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	882,649.17	0.00	REHAB THERAPY	16,351.92	0.00
RESPIRATORY SERVICES	7,540,652.57	9,884.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,605,334.97	0.00	AMBULANCE	0.00	0.00
GI SERVICES	284,796.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,940,198.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,510,014.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	92,434.42
LABORATORY PATHOLOGIC	258,291.52	0.00	INJECTABLE DRUGS	11,156,007.08	86.29
RADIOLOGY THERAPEUTIC	615,443.96	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	741,364.56	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	369,889.95	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	425,038.60	586,611.27	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	33,220.09	6,617.02	TRAUMA RESPONSE	0.00	698,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,817,712.39	0.02
LITHOTRIPSY	18,353.75	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	815,548.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,379,569.72	73,237.91			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	354,039.50	715.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,927,457.32	750.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	152,686.87	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	344,591.94	0.00			

TOTAL ANCILLARY	95,918,151.39	2,180,244.51
TOTAL ACCOMODATIONS	33,166,090.90	7,636,262.24
TOTAL CHARGES	129,084,242.29	9,816,506.75

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,349,408.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,268,086.75	CONTRACTUAL ALLOW	749,520.56
NON-COVERD CHARGES	81,321.25	TOTAL MEDICAID LIAB	518,566.19
		LESS: COB	518,566.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	70	0	63,992.00	35,684.00
ROUTINE NURSERY	122	0	267,110.00	41,362.25
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	192	0	331,102.00	77,046.25
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	16	0	78,920.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	78,920.00	0.00
TOTAL ACCOMODATIONS	208	0	410,022.00	77,046.25

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,816.14	0.00	OTHER LAB	950.82	0.00
MED/SURG SUPPLY	116,185.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	86,516.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,635.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,957.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,159.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	126,362.29	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,273.76	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	185,774.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,574.49	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,513.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,449.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,655.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	831.27	0.00	INJECTABLE DRUGS	57,422.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,828.69	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	590.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,777.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,079.91	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,022.50	4,275.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,988.84	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,697.43	0.00			

TOTAL ANCILLARY	858,064.75	4,275.00
TOTAL ACCOMODATIONS	410,022.00	77,046.25
TOTAL CHARGES	1,268,086.75	81,321.25

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,174,742.29	ADJUSTMENTS	388,340.20
COVERED CHARGES	30,271,401.97	CONTRACTUAL ALLOW	25,506,397.05
NON-COVERD CHARGES	5,903,340.32	TOTAL MEDICAID LIAB	4,765,004.92
		LESS: COB	24,418.87
		LESS: COPAYMENT	9,287.20
		REIMBURSEMENT	4,731,298.85
		ALL OTHER	4,397,698.27
		FEE SCHEDULE-LAB	333,600.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9,603

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,379.13	17.50	OTHER LAB	675,361.46	3,083.75
MED/SURG SUPPLY	964,546.10	249,023.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	3,025.94
RADIOLOGY-DIAGNOSTIC	1,615,149.01	124,601.31	OTHER THERAPEUTIC SVC	0.00	1,684.28
CT SCAN	2,111,504.77	570,754.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	119,201.33	69,821.83	FEE SCHEDULE LAB	3,171,256.32	284,298.78
EKG/ECG	313,466.21	678.75	MRI SERVICES	776,868.14	156,057.09
IV THERAPY	1,058,657.19	20,591.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,972,108.37	1,383,059.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,669.47	5,371.43	REHAB THERAPY	0.00	585.00
RESPIRATORY SERVICES	170,227.76	638.47	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,834,763.03	0.00	AMBULANCE	0.00	0.00
GI SERVICES	292,037.85	175,801.57	CAST ROOM	1,794.00	0.00
EMERGENCY ROOM	9,023,950.77	32,623.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	774,623.99	0.00	DRUG-SPECIFIC/HOME IV	0.00	650.01
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	1,197,141.26	1,417,068.60	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,616.26	45,689.51	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,104.48	27,016.56	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,748.41	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120,727.01	43,751.55	TRAUMA RESPONSE	0.00	346,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,551.42	229,839.17
LITHOTRIPSY	22,795.35	0.00	NO CC/INVALID REV CODE	0.00	3,466.34
OTHER IMAGING SERVICE	704,008.80	157,346.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,446.10	247.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	488,394.53	147,844.59			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	196,646.49	366,685.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,128.89	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	645,276.48	28,268.53			

TOTAL ANCILLARY	30,271,401.97	5,903,340.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,271,401.97	5,903,340.32

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 02/01/18 THROUGH 01/31/19
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	2018180066765	02/01/18 - 02/01/18	07/09/18	0.00	2,897.34	0.00	0.00	0.00
614	2018180066765	02/01/18 - 02/01/18	07/09/18	0.00	569.00	0.00	0.00	0.00
TOTAL				0.00	3,466.34	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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	792,998.44	ADJUSTMENTS	0.00
COVERED CHARGES	472,804.37	CONTRACTUAL ALLOW	273,687.83
NON-COVERD CHARGES	320,194.07	TOTAL MEDICAID LIAB	199,116.54
		LESS: COB	199,063.51
		LESS: COPAYMENT	53.03
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 143

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,854.43	0.00	OTHER LAB	17,821.63	0.00
MED/SURG SUPPLY	18,994.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,993.67	1,318.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,834.31	29,995.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,441.59	2,320.82
EKG/ECG	690.00	230.00	MRI SERVICES	3,621.68	53,369.49
IV THERAPY	9,023.13	3,425.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,056.86	53,925.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,221.25	1,535.43	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,836.62	877.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,497.57	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,983.24	2,753.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,242.93	6,957.31	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,257.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	8,749.35	371.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,339.52	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,239.53	312.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	958.70	98,503.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,328.82	49,734.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,719.12	5,588.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,272.80	7,590.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,165.09	46.05			

TOTAL ANCILLARY	472,804.37	320,194.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	472,804.37	320,194.07

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,210,630.30	ADJUSTMENTS	22,674.73
COVERED CHARGES	1,196,246.89	CONTRACTUAL ALLOW	1,145,597.69
NON-COVERD CHARGES	14,383.41	TOTAL MEDICAID LIAB	50,649.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,299.00
		REIMBURSEMENT	49,350.20
		TOTAL NUMBER OF CLAIMS	793

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,471.11	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,381.60	335.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,429.82	2,402.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,834.70	8,187.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	503.01	594.60	FEE SCHEDULE LAB	81,724.90	1,406.71
EKG/ECG	8,495.74	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,598.50	226.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,476.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,497.64	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	931,518.55	945.65	SPECIAL SERVICES	0.00	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	1,929.35	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,209.16	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,176.56	0.00			

TOTAL ANCILLARY	1,196,246.89	14,383.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,196,246.89	14,383.41

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	54,771.25	ADJUSTMENTS	0.00
COVERED CHARGES	42,932.27	CONTRACTUAL ALLOW	30,918.32
NON-COVERD CHARGES	11,838.98	TOTAL MEDICAID LIAB	12,013.95
		LESS: COB	12,001.95
		LESS: COPAYMENT	12.00
		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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204.55	62.15	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	367.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,886.22	318.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,756.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,529.16	1,656.25
EKG/ECG	285.66	230.00	MRI SERVICES	0.00	0.00
IV THERAPY	910.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.50	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	25,469.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,021.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,550.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,045.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,105.20	0.00			

TOTAL ANCILLARY	42,932.27	11,838.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,932.27	11,838.98

GEORGIA 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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,501,947.69	ADJUSTMENTS	24,798.84
COVERED CHARGES	4,448,763.71	CONTRACTUAL ALLOW	4,082,687.58
NON-COVERD CHARGES	1,053,183.98	TOTAL MEDICAID LIAB	366,076.13
		LESS: COB	0.00
		LESS: COPAYMENT	543.50
		REIMBURSEMENT	365,532.63
		TOTAL NUMBER OF CLAIMS	59

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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,551.19	0.00	OTHER LAB	3,077.69	0.00
MED/SURG SUPPLY	280,694.33	129,546.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,749.98	43,589.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	257.50	1,034.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,481.27	FEE SCHEDULE LAB	28,383.56	8,061.45
EKG/ECG	2,570.48	0.00	MRI SERVICES	0.00	6,091.02
IV THERAPY	6,072.69	195.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	955,462.19	82,855.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	390.00
RESPIRATORY SERVICES	560.00	41.69	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	210,263.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,569.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,432.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	615,355.54	5,668.80	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,145.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	663.55	2,965.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,988,455.59	446,969.13
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,996.85	1,021.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,430.87	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,241.29	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,913.75	319,573.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,059.82	1,554.75			

TOTAL ANCILLARY	4,448,763.71	1,053,183.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,448,763.71	1,053,183.98

GEORGIA DEPARTMENT OF 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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	89,999.21	ADJUSTMENTS	0.00
COVERED CHARGES	83,130.46	CONTRACTUAL ALLOW	52,637.94
NON-COVERD CHARGES	6,868.75	TOTAL MEDICAID LIAB	30,492.52
		LESS: COB	30,489.52
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	620.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	389.59	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	6,868.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,340.00	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	1,498.75	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	77,281.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	83,130.46	6,868.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,130.46	6,868.75

** 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	112,187.37	ADJUSTMENTS	0.00
COVERED CHARGES	111,319.37	CONTRACTUAL ALLOW	45,196.02
NON-COVERD CHARGES	868.00	TOTAL MEDICAID LIAB	66,123.35
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	66,123.35

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	26,000.00	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	50	0	26,000.00	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	50	0	26,000.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,120.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,200.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,043.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,754.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,441.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,793.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,096.00	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	378.08	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,809.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,250.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,309.53	0.00	INJECTABLE DRUGS	16,457.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,345.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	849.00	0.00			
BLOOD	2,418.00	0.00			
BLOOD STORAGE & PRO.	930.84	868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,125.00	0.00			

TOTAL ANCILLARY	85,319.37	868.00
TOTAL ACCOMODATIONS	26,000.00	0.00
TOTAL CHARGES	111,319.37	868.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	567,096.35	ADJUSTMENTS	3,390.14
COVERED CHARGES	501,645.72	CONTRACTUAL ALLOW	339,476.25
NON-COVERD CHARGES	65,450.63	TOTAL MEDICAID LIAB	162,169.47
		LESS: COB	421.01
		LESS: COPAYMENT	328.08
		REIMBURSEMENT	161,420.38
		ALL OTHER	148,101.46
		FEE SCHEDULE-LAB	11,357.55
		INJECTABLE DRUGS	1,961.37

TOTAL NUMBER OF CLAIMS 537

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,387.00	6,977.00	OTHER LAB	5,407.00	0.00
MED/SURG SUPPLY	6,348.07	544.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,562.00	8,710.00	OTHER THERAPEUTIC SVC	0.00	11,439.20
CT SCAN	51,579.00	3,639.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,608.59	9,472.00
EKG/ECG	13,362.00	2,882.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,679.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,594.00	3,572.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,816.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,570.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	237,906.75	992.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,805.00	7,554.25
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	630.35	90.05	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,794.00	656.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	452.00			
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	10,596.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	4,700.00			

TOTAL ANCILLARY	501,645.72	65,450.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	501,645.72	65,450.63

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,496.27	ADJUSTMENTS	0.00
COVERED CHARGES	1,307.00	CONTRACTUAL ALLOW	310.91
NON-COVERD CHARGES	189.27	TOTAL MEDICAID LIAB	996.09
		LESS: COB	996.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	21.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4.00	50.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	110.00	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	1,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	8.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,307.00	189.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,307.00	189.27

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,647.06	ADJUSTMENTS	1,346.00
COVERED CHARGES	37,320.06	CONTRACTUAL ALLOW	34,600.06
NON-COVERD CHARGES	3,327.00	TOTAL MEDICAID LIAB	2,720.00
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	2,609.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94.00	328.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	286.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	328.00
CT SCAN	2,266.00	1,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,000.00	532.00
EKG/ECG	524.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	322.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	28,300.60	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	809.00	480.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	184.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	37,320.06	3,327.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,320.06	3,327.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	846.50	ADJUSTMENTS	0.00
COVERED CHARGES	770.00	CONTRACTUAL ALLOW	698.28
NON-COVERD CHARGES	76.50	TOTAL MEDICAID LIAB	71.72
		LESS: COB	71.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	170.00	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	600.00	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	76.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	770.00	76.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	770.00	76.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,519,155.09	ADJUSTMENTS	19,026.11
COVERED CHARGES	2,487,795.09	CONTRACTUAL ALLOW	1,440,309.01
NON-COVERD CHARGES	31,360.00	TOTAL MEDICAID LIAB	1,047,486.08
		LESS: COB	897.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,046,588.58

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	544	0	209,055.00	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	544	0	209,055.00	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	544	0	209,055.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840,637.19	0.00	OTHER LAB	7,343.00	0.00
MED/SURG SUPPLY	426,760.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	362,360.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	103,163.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,760.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,649.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,456.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,523.00	12,800.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	173,082.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,813.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,036.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	450.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,159.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,275.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,713.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,150.00	18,560.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,303.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	65,121.00	0.00			

TOTAL ANCILLARY	2,278,740.09	31,360.00
TOTAL ACCOMODATIONS	209,055.00	0.00
TOTAL CHARGES	2,487,795.09	31,360.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,080,454.88	ADJUSTMENTS	113,107.97
COVERED CHARGES	6,130,259.28	CONTRACTUAL ALLOW	3,970,008.44
NON-COVERD CHARGES	950,195.60	TOTAL MEDICAID LIAB	2,160,250.84
		LESS: COB	54.15
		LESS: COPAYMENT	1,419.00
		REIMBURSEMENT	2,158,777.69
		ALL OTHER	1,925,061.54
		FEE SCHEDULE-LAB	233,529.56
		INJECTABLE DRUGS	186.59

TOTAL NUMBER OF CLAIMS 8,976

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,584.73	129,700.69	OTHER LAB	54,887.00	0.00
MED/SURG SUPPLY	597,659.65	8,878.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	898.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	376,739.00	17,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	329,207.00	50,922.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,432.00	210.00	FEE SCHEDULE LAB	1,529,949.60	299,978.00
EKG/ECG	14,993.00	981.00	MRI SERVICES	11,374.00	0.00
IV THERAPY	30,485.00	7,110.00	PROFESSIONAL FEES	0.00	769.00
OPERATING ROOM	610,940.00	82,139.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,589.00	5,971.00	FREE STANDING CLINIC	115.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,255.00	21,335.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	269,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	448.30	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	2,826.00	628.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,632.00	131.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,073.00	1,479.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	81,676.00	31,186.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,755.00	2,749.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,624,389.00	287,889.00			

TOTAL ANCILLARY	6,130,259.28	950,195.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,130,259.28	950,195.60

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,369.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,335.10	CONTRACTUAL ALLOW	2,090.58
NON-COVERD CHARGES	6,033.90	TOTAL MEDICAID LIAB	10,244.52
		LESS: COB	10,244.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254.90	423.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	659.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,070.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,488.00	1,586.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	1,936.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,650.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	17.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	308.00	438.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,335.10	6,033.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,335.10	6,033.90

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,199.95	ADJUSTMENTS	0.00
COVERED CHARGES	73,238.00	CONTRACTUAL ALLOW	68,860.00
NON-COVERD CHARGES	8,961.95	TOTAL MEDICAID LIAB	4,378.00
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	4,210.00
		TOTAL NUMBER OF CLAIMS	98

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,691.75	2,229.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,946.25	83.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,492.00	145.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,902.00	1,528.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,689.00	1,856.00
EKG/ECG	218.00	109.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,214.00	546.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,600.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,460.00	819.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	949.00	1,646.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,238.00	8,961.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,238.00	8,961.95

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	273.00	ADJUSTMENTS	0.00
COVERED CHARGES	273.00	CONTRACTUAL ALLOW	85.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	187.28
		LESS: COB	184.28
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	273.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	273.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	273.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,280.05	ADJUSTMENTS	14,863.23
COVERED CHARGES	75,459.85	CONTRACTUAL ALLOW	50,677.80
NON-COVERD CHARGES	6,820.20	TOTAL MEDICAID LIAB	24,782.05
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	24,776.05
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,042.40	1,698.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,464.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	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	3,893.00	2,317.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,028.00	1,035.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,100.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,050.00	448.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41.00	394.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,750.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,457.00	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	33,344.00	0.00			

TOTAL ANCILLARY	75,459.85	6,820.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	75,459.85	6,820.20

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	499,111.61	ADJUSTMENTS	0.00
COVERED CHARGES	466,591.61	CONTRACTUAL ALLOW	226,329.20
NON-COVERD CHARGES	32,520.00	TOTAL MEDICAID LIAB	240,262.41
		LESS: COB	6,059.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	234,203.02

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	147	0	151,410.00	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	147	0	151,410.00	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	147	0	151,410.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,596.70	0.00	OTHER LAB	3,473.00	0.00
MED/SURG SUPPLY	6,083.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,623.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,085.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,160.00	29,366.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,828.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,682.00	0.00	MRI SERVICES	2,462.00	0.00
IV THERAPY	14,473.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,262.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,090.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,878.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,521.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,076.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	615.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66.00	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	NO CC/INVALID REV CODE	0.00	2,531.00
OTHER IMAGING SERVICE	374.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,860.00	623.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,704.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	783.00	0.00			

TOTAL ANCILLARY	315,181.61	32,520.00
TOTAL ACCOMODATIONS	151,410.00	0.00
TOTAL CHARGES	466,591.61	32,520.00

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 07/01/17 THROUGH 06/30/18
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	2017248098684	08/20/17 - 08/22/17	09/11/17	0.00	2,531.00	0.00	0.00	0.00
TOTAL				0.00	2,531.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,466,061.60	ADJUSTMENTS	59,222.93
COVERED CHARGES	2,259,889.10	CONTRACTUAL ALLOW	1,704,898.35
NON-COVERD CHARGES	206,172.50	TOTAL MEDICAID LIAB	554,990.75
		LESS: COB	502.72
		LESS: COPAYMENT	1,152.00
		REIMBURSEMENT	553,336.03
		ALL OTHER	488,356.91
		FEE SCHEDULE-LAB	54,615.16
		INJECTABLE DRUGS	10,363.96

TOTAL NUMBER OF CLAIMS 1,582

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,181.28	0.00	OTHER LAB	18,038.00	0.00
MED/SURG SUPPLY	15,731.00	2,888.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,564.00	3,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	356,188.00	38,074.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,528.00	6,415.00	FEE SCHEDULE LAB	419,450.00	29,666.00
EKG/ECG	28,757.00	2,086.00	MRI SERVICES	114,621.00	10,652.00
IV THERAPY	132,793.00	25,022.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,447.00	16,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,541.00	1,544.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,917.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	513,963.00	7,632.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,889.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	176,896.82	24,833.50
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	427.00	279.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	792.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,588.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,355.00	5,733.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,776.00	13,706.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,658.00	10,344.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,686.00	4,278.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,201.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,281.00	0.00			

TOTAL ANCILLARY	2,259,889.10	206,172.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,259,889.10	206,172.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,005.65	ADJUSTMENTS	0.00
COVERED CHARGES	25,624.65	CONTRACTUAL ALLOW	14,310.81
NON-COVERD CHARGES	7,381.00	TOTAL MEDICAID LIAB	11,313.84
		LESS: COB	11,310.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	584.60	0.00	OTHER LAB	481.00	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	1,126.00	907.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,790.00	3,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,895.00	85.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,525.00	64.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,622.00	564.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	863.05	412.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,010.00	2,205.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,624.65	7,381.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,624.65	7,381.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	119,073.95	ADJUSTMENTS	0.00
COVERED CHARGES	112,662.35	CONTRACTUAL ALLOW	104,162.35
NON-COVERD CHARGES	6,411.60	TOTAL MEDICAID LIAB	8,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	8,305.00
		TOTAL NUMBER OF CLAIMS	170

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,403.16	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	6,370.00	548.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,640.00	3,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,009.00	FEE SCHEDULE LAB	22,106.00	377.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,126.00	451.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	396.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,222.00	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	6,456.19	424.60
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,496.00	458.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,662.35	6,411.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	112,662.35	6,411.60

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,227.35	ADJUSTMENTS	0.00
COVERED CHARGES	2,227.35	CONTRACTUAL ALLOW	1,402.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	824.75
		LESS: COB	824.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.35	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	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	588.00	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	1,617.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,227.35	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,227.35	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,749.45	ADJUSTMENTS	0.00
COVERED CHARGES	90,145.45	CONTRACTUAL ALLOW	80,174.57
NON-COVERD CHARGES	3,604.00	TOTAL MEDICAID LIAB	9,970.88
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	9,892.88

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,728.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,057.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	280.00	280.00	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	349.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,895.00	1,485.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,623.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,636.00	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	6,157.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,419.98	114.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,725.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	90,145.45	3,604.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,145.45	3,604.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,201.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,826.00	CONTRACTUAL ALLOW	7,484.51
NON-COVERD CHARGES	375.00	TOTAL MEDICAID LIAB	4,341.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,341.49

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	1,881.00	375.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,881.00	375.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,881.00	375.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,595.00	0.00	OTHER LAB	698.00	0.00
MED/SURG SUPPLY	164.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,207.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,662.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,346.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,945.00	0.00
TOTAL ACCOMODATIONS	1,881.00	375.00
TOTAL CHARGES	11,826.00	375.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,957,800.03	ADJUSTMENTS	76,101.14
COVERED CHARGES	1,860,213.00	CONTRACTUAL ALLOW	1,477,554.70
NON-COVERD CHARGES	97,587.03	TOTAL MEDICAID LIAB	382,658.30
		LESS: COB	0.00
		LESS: COPAYMENT	1,464.00
		REIMBURSEMENT	381,194.30
		ALL OTHER	321,031.89
		FEE SCHEDULE-LAB	56,348.16
		INJECTABLE DRUGS	3,814.25

TOTAL NUMBER OF CLAIMS 1,841

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	274,975.00	70.00	OTHER LAB	4,622.00	0.00
MED/SURG SUPPLY	16,309.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125,655.00	687.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	291,543.00	47,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,169.00	12,205.00	FEE SCHEDULE LAB	501,628.00	21,949.00
EKG/ECG	12,136.00	0.00	MRI SERVICES	10,966.00	0.00
IV THERAPY	19,242.00	1,523.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,218.00	2,368.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,719.00	5,681.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,491.00	3,140.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,194.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,584.00	595.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	539.00	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	NO CC/INVALID REV CODE	207.00	0.00
OTHER IMAGING SERVICE	35,105.00	965.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	504.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,836.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,110.00	0.00			

TOTAL ANCILLARY	1,860,213.00	97,587.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,860,213.00	97,587.03

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 10/01/17 THROUGH 09/30/18
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	2018108006816	04/11/18 - 04/11/18	04/23/18	69.00	0.00	0.00	0.00	20.52
780	2018128006450	05/01/18 - 05/01/18	05/14/18	69.00	0.00	0.00	0.00	20.52
780	2018128007068	05/01/18 - 05/01/18	05/14/18	69.00	0.00	0.00	0.00	20.52
TOTAL				207.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,078.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,629.00	CONTRACTUAL ALLOW	1,838.08
NON-COVERD CHARGES	3,449.00	TOTAL MEDICAID LIAB	3,790.92
		LESS: COB	3,787.92
		LESS: COPAYMENT	3.00
		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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	109.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	726.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,627.00	212.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,546.00	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	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,629.00	3,449.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,629.00	3,449.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,532.00	ADJUSTMENTS	558.00
COVERED CHARGES	47,171.00	CONTRACTUAL ALLOW	42,891.00
NON-COVERD CHARGES	361.00	TOTAL MEDICAID LIAB	4,280.00
		LESS: COB	21.17
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	4,162.83
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	773.00	20.00	OTHER LAB	698.00	0.00
MED/SURG SUPPLY	187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,132.00	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	12,913.00	341.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,957.00	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	1,844.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	358.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,171.00	361.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,171.00	361.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	95,103.00	ADJUSTMENTS	0.00
COVERED CHARGES	94,302.00	CONTRACTUAL ALLOW	74,476.36
NON-COVERD CHARGES	801.00	TOTAL MEDICAID LIAB	19,825.64
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	19,798.64

TOTAL NUMBER OF CLAIMS 4

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

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,742.00	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	1,753.00	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	11,807.00	801.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	94,302.00	801.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,302.00	801.00

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

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,261.61	ADJUSTMENTS	5,035.59
COVERED CHARGES	119,205.61	CONTRACTUAL ALLOW	35,592.20
NON-COVERD CHARGES	1,056.00	TOTAL MEDICAID LIAB	83,613.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	83,613.41

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	38	0	17,670.00	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	38	0	17,670.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	908.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	908.00	0.00
TOTAL ACCOMODATIONS	39	0	18,578.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,446.27	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,618.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,632.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,748.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,115.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	394.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,561.00	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	2,810.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,798.00	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	4,560.70	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,944.00	1,056.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	100,627.61	1,056.00
TOTAL ACCOMODATIONS	18,578.00	0.00
TOTAL CHARGES	119,205.61	1,056.00

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

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	545,716.06	ADJUSTMENTS	24,549.52
COVERED CHARGES	451,814.16	CONTRACTUAL ALLOW	282,695.16
NON-COVERD CHARGES	93,901.90	TOTAL MEDICAID LIAB	169,119.00
		LESS: COB	60.06
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	168,821.94
		ALL OTHER	157,652.79
		FEE SCHEDULE-LAB	9,026.89
		INJECTABLE DRUGS	2,142.26

TOTAL NUMBER OF CLAIMS 470

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,634.84	12,758.90	OTHER LAB	539.00	0.00
MED/SURG SUPPLY	1,807.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,027.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,132.00	7,290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,567.00	48,949.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,902.00	9,661.00
EKG/ECG	8,069.00	486.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,399.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	780.00	564.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,015.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	171,829.00	3,890.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,401.00	3,599.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	293.00
OTHER IMAGING SERVICE	12,094.00	1,906.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	648.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,917.00	2,037.00			

TOTAL ANCILLARY	451,814.16	93,901.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	451,814.16	93,901.90

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 10/01/17 THROUGH 09/30/18
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
407	2218158008321	05/21/18 - 05/21/18	06/11/18	0.00	33.00	0.00	0.00	0.00
405	2218233004488	04/09/18 - 04/09/18	08/27/18	0.00	260.00	0.00	0.00	0.00
TOTAL				0.00	293.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,499.20	ADJUSTMENTS	0.00
COVERED CHARGES	10,146.20	CONTRACTUAL ALLOW	3,348.44
NON-COVERD CHARGES	353.00	TOTAL MEDICAID LIAB	6,797.76
		LESS: COB	6,797.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	327.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	258.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,902.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,019.00	95.00
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	493.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,036.00	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	5.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,146.20	353.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,146.20	353.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	72,386.83	ADJUSTMENTS	1,137.00
COVERED CHARGES	66,733.83	CONTRACTUAL ALLOW	61,403.83
NON-COVERD CHARGES	5,653.00	TOTAL MEDICAID LIAB	5,330.00
		LESS: COB	43.18
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	5,073.82
		TOTAL NUMBER OF CLAIMS	99

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,135.00	1,661.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	143.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	19.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,496.00	286.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,567.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,292.00	1,166.00
EKG/ECG	648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	34,028.00	96.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	424.00	957.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	66,733.83	5,653.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,733.83	5,653.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,135,619.17	ADJUSTMENTS	5,117.81
COVERED CHARGES	1,070,024.30	CONTRACTUAL ALLOW	761,463.54
NON-COVERD CHARGES	65,594.87	TOTAL MEDICAID LIAB	308,560.76
		LESS: COB	1,211.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	307,349.10

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	124	0	103,693.00	46,593.18
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	124	0	103,693.00	46,593.18
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	124	0	103,693.00	46,593.18

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,438.39	0.00	OTHER LAB	3,288.48	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	261,282.09	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,713.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,804.28	19,001.69	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	62,949.07	0.00	MRI SERVICES	6,948.07	0.00
IV THERAPY	24,949.15	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	152,840.13	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,724.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	215,176.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.62	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,370.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,123.09	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,623.20	0.00			

TOTAL ANCILLARY	966,331.30	19,001.69
TOTAL ACCOMODATIONS	103,693.00	46,593.18
TOTAL CHARGES	1,070,024.30	65,594.87

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,640,278.96	ADJUSTMENTS	76,020.95
COVERED CHARGES	6,183,339.49	CONTRACTUAL ALLOW	5,468,404.38
NON-COVERD CHARGES	456,939.47	TOTAL MEDICAID LIAB	714,935.11
		LESS: COB	1,040.02
		LESS: COPAYMENT	1,847.28
		REIMBURSEMENT	712,047.81
		ALL OTHER	619,377.57
		FEE SCHEDULE-LAB	83,176.68
		INJECTABLE DRUGS	9,493.56

TOTAL NUMBER OF CLAIMS 2,189

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,138.21	11,153.61	OTHER LAB	10,362.37	0.00
MED/SURG SUPPLY	12,689.06	581.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	307,728.86	7,916.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	682,850.58	56,279.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	298,501.72	7,553.40	FEE SCHEDULE LAB	1,492,649.56	143,836.60
EKG/ECG	181,288.92	8,866.53	MRI SERVICES	90,523.62	3,789.38
IV THERAPY	512,294.83	96,705.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	163,595.69	26,330.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,745.58	6,011.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,785.00	3,405.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,916,980.35	26,551.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,197.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	254,363.68	21,380.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,286.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	15,623.36
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,389.04	10,179.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,462.80	8,487.60			
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	40,744.62	0.00			

TOTAL ANCILLARY	6,183,339.49	456,939.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,183,339.49	456,939.47

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,256.06	ADJUSTMENTS	0.00
COVERED CHARGES	31,073.62	CONTRACTUAL ALLOW	14,403.47
NON-COVERD CHARGES	4,182.44	TOTAL MEDICAID LIAB	16,670.15
		LESS: COB	16,667.15
		LESS: COPAYMENT	3.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	561.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,042.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,560.87	1,744.22
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,822.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	16,218.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,798.40	4.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,111.82	391.66			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,073.62	4,182.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,073.62	4,182.44

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	330,840.29	ADJUSTMENTS	4,518.88
COVERED CHARGES	314,241.25	CONTRACTUAL ALLOW	300,669.77
NON-COVERD CHARGES	16,599.04	TOTAL MEDICAID LIAB	13,571.48
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	13,238.48
		TOTAL NUMBER OF CLAIMS	199

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	145.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,182.90	1,379.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,117.42	4,302.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,242.47	7,305.72
EKG/ECG	2,450.38	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,753.67	620.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	768.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,978.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,645.54	2,022.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	822.48	822.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	314,241.25	16,599.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	314,241.25	16,599.04

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,206.62	ADJUSTMENTS	0.00
COVERED CHARGES	4,206.62	CONTRACTUAL ALLOW	2,371.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,834.79
		LESS: COB	1,834.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	488.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,303.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,414.12	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,206.62	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,206.62	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	509,382.88	ADJUSTMENTS	31,997.88
COVERED CHARGES	445,042.64	CONTRACTUAL ALLOW	413,026.76
NON-COVERD CHARGES	64,340.24	TOTAL MEDICAID LIAB	32,015.88
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	31,997.88

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	717.26	116.47	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,657.13	3,463.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,240.80	1,376.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,042.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,889.23	0.00
EKG/ECG	987.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	272.74	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	233,688.34	21,375.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,745.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,349.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,757.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98,101.69	4,679.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,594.10	33,328.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	445,042.64	64,340.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	445,042.64	64,340.24

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,960,672.21	ADJUSTMENTS	152,498.63
COVERED CHARGES	13,328,508.21	CONTRACTUAL ALLOW	9,685,322.71
NON-COVERD CHARGES	632,164.00	TOTAL MEDICAID LIAB	3,643,185.50
		LESS: COB	44,625.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,598,559.79

TOTAL NUMBER OF ADMISSIONS 402

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	991	0	658,024.00	525,707.00
ROUTINE NURSERY	109	0	146,648.00	38,292.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,100	0	804,672.00	563,999.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	235	0	798,491.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	235	0	798,491.00	0.00
TOTAL ACCOMODATIONS	1,335	0	1,603,163.00	563,999.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,822,429.08	0.00	OTHER LAB	135,748.00	0.00
MED/SURG SUPPLY	212,427.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,020,255.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	231,064.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,138,854.00	4,180.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	191,849.92	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	144,861.00	0.00	MRI SERVICES	110,036.00	0.00
IV THERAPY	886.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	923,060.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	140,552.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,172,624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,166.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	125,757.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,341,224.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	194,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	19,535.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,835.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,797.26	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	272,115.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,293.00	4,586.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	345,323.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	97,294.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	290,654.00	39,710.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,301.00	19,689.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	351,768.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,682.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,354.75	0.00			

TOTAL ANCILLARY	11,725,345.21	68,165.00
TOTAL ACCOMODATIONS	1,603,163.00	563,999.00
TOTAL CHARGES	13,328,508.21	632,164.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,213.32	ADJUSTMENTS	0.00
COVERED CHARGES	18,699.32	CONTRACTUAL ALLOW	6,078.97
NON-COVERD CHARGES	1,514.00	TOTAL MEDICAID LIAB	12,620.35
		LESS: COB	12,620.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,328.00	1,514.00
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	1,328.00	1,514.00
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	1,328.00	1,514.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,159.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	485.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	382.00	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	7,946.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,266.00	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	3,369.00	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	1,526.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,371.32	0.00
TOTAL ACCOMODATIONS	1,328.00	1,514.00
TOTAL CHARGES	18,699.32	1,514.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,813,426.18	ADJUSTMENTS	533,734.28
COVERED CHARGES	13,579,607.09	CONTRACTUAL ALLOW	10,884,432.55
NON-COVERD CHARGES	2,233,819.09	TOTAL MEDICAID LIAB	2,695,174.54
		LESS: COB	20,179.05
		LESS: COPAYMENT	2,928.00
		REIMBURSEMENT	2,672,067.49
		ALL OTHER	2,516,499.69
		FEE SCHEDULE-LAB	127,100.24
		INJECTABLE DRUGS	28,467.56

TOTAL NUMBER OF CLAIMS 3,518

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,163.27	0.00	OTHER LAB	197,020.00	1,913.00
MED/SURG SUPPLY	143,008.56	11,164.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	661,882.00	141,720.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,605,506.00	528,873.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	74,694.00	47,989.28	FEE SCHEDULE LAB	1,928,206.00	89,430.00
EKG/ECG	232,681.00	7,088.00	MRI SERVICES	331,369.00	55,935.00
IV THERAPY	79,365.00	5,636.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	505,052.00	353,190.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,091.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,929.00	264,530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,835.00	1,738.00	AMBULANCE	0.00	0.00
GI SERVICES	28,347.00	3,066.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,762,164.00	228,042.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	199,046.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,182.69	216,955.09
RADIOLOGY THERAPEUTIC	1,988.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	8,805.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,188.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	57,272.00	8,934.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,438.12	32,215.19
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	534.00
OTHER IMAGING SERVICE	318,344.00	85,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,411.00	4,180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	125,959.00	65,808.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	123,192.00	20,826.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	110,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	321,333.45	25,797.00			

TOTAL ANCILLARY	13,579,607.09	2,233,819.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,579,607.09	2,233,819.09

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 07/01/17 THROUGH 06/30/18
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	2218127006103	07/12/17 - 07/12/17	05/14/18	0.00	534.00	0.00	0.00	0.00
TOTAL				0.00	534.00	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 NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,017.34	ADJUSTMENTS	0.00
COVERED CHARGES	49,855.94	CONTRACTUAL ALLOW	29,081.49
NON-COVERD CHARGES	28,161.40	TOTAL MEDICAID LIAB	20,774.45
		LESS: COB	20,762.45
		LESS: COPAYMENT	12.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	881.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,604.00	3,466.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,864.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,732.00	440.00
EKG/ECG	1,329.00	0.00	MRI SERVICES	0.00	7,890.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	760.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	982.00	755.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,519.00	1,135.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,148.38	120.40
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	406.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,727.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	7,668.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,230.00	3,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,331.30	0.00			

TOTAL ANCILLARY	49,855.94	28,161.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,855.94	28,161.40

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	371,360.81	ADJUSTMENTS	158.82
COVERED CHARGES	342,233.53	CONTRACTUAL ALLOW	332,723.73
NON-COVERD CHARGES	29,127.28	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	261.00
		REIMBURSEMENT	9,248.80
		TOTAL NUMBER OF CLAIMS	170

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,637.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	433.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,631.00	8,572.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,804.00	12,771.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,963.00	368.00
EKG/ECG	4,430.00	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	702.00	740.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,895.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204,638.00	1,297.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,334.64	4,217.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,797.00	1,162.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,968.45	0.00			

TOTAL ANCILLARY	342,233.53	29,127.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,233.53	29,127.28

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,020.85	ADJUSTMENTS	0.00
COVERED CHARGES	4,443.85	CONTRACTUAL ALLOW	2,923.78
NON-COVERD CHARGES	577.00	TOTAL MEDICAID LIAB	1,520.07
		LESS: COB	1,520.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
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PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	727.00	537.00	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	532.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,161.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,443.85	577.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,443.85	577.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,037,456.97	ADJUSTMENTS	55,416.30
COVERED CHARGES	945,767.79	CONTRACTUAL ALLOW	805,301.97
NON-COVERD CHARGES	91,689.18	TOTAL MEDICAID LIAB	140,465.82
		LESS: COB	6,007.20
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	134,314.62
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,050.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38,945.85	8,876.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,739.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,293.00	7,910.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,520.02	FEE SCHEDULE LAB	16,029.00	1,123.00
EKG/ECG	1,329.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	243,893.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,561.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,978.00	736.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	338,016.68	7,173.07
RADIOLOGY THERAPEUTIC	13,229.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	499.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,788.00	58,894.57
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,188.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,759.20	0.00			

TOTAL ANCILLARY	945,767.79	91,689.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	945,767.79	91,689.18

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,201,574.30	ADJUSTMENTS	9,799,866.88
COVERED CHARGES	154,940,235.61	CONTRACTUAL ALLOW	122,407,283.84
NON-COVERD CHARGES	7,261,338.69	TOTAL MEDICAID LIAB	32,532,951.77
		LESS: COB	294,708.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,238,243.01

TOTAL NUMBER OF ADMISSIONS 5,575

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,527	0	12,931,526.00	1,414,448.00
ROUTINE NURSERY	9,847	0	17,424,341.00	3,780,294.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20,374	0	30,355,867.00	5,194,742.00
SPECIAL CARE SERVICES				
CCU	13	0	57,213.00	0.00
ICU	2,758	0	11,485,324.00	15,996.00
NICU	1,142	0	7,410,287.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,913	0	18,952,824.00	15,996.00
TOTAL ACCOMODATIONS	24,287	0	49,308,691.00	5,210,738.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,121,557.13	168,615.97	OTHER LAB	546,635.00	2,700.00
MED/SURG SUPPLY	3,289,723.64	92,183.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,398,351.82	294,090.22	EDUCATION & TRAINING	13,555.00	929.00
RADIOLOGY-DIAGNOSTIC	1,706,155.50	1,912.00	OTHER THERAPEUTIC SVC	0.00	30,449.00
CT SCAN	2,519,784.00	5,616.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	869,960.00	27,172.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	333,540.00	736.00	MRI SERVICES	958,723.00	11,080.00
IV THERAPY	288,938.00	10,198.00	PROFESSIONAL FEES	0.00	390.00
OPERATING ROOM	6,783,273.00	114,081.00	DURABLE MED. EQUIP.	0.00	3,197.00
LABOR/DELIVERY ROOM	9,773,026.50	9,804.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,949,456.03	16,056.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,275,040.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,277,938.00	1,479.00	SPECIAL SERVICES	0.00	31,258.00
RECOVERY ROOM	1,880,938.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	67,384.00
LABORATORY PATHOLOGIC	1,656,300.00	0.00	INJECTABLE DRUGS	22,920,103.35	24,381.00
RADIOLOGY THERAPEUTIC	834,835.00	9,487.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	771,769.00	12,821.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	329,056.00	2,709.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	590,636.00	71,348.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	254.00	3,860.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	440.00	0.00	IMPL DEV CHARGE PATIENTS	834,268.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	922,882.00	110,415.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,054,925.00	880,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	245,258.00	33,360.00			
AUDIOLOGY	777,123.00	0.00			
CARDIOLOGY	1,493,065.00	12,826.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	140,902.00	0.00			
ORGAN ACQUISITION	8,463.64	0.00			
TREATMENT/OBSERV. RM	56,797.00	0.00			

TOTAL ANCILLARY	105,631,544.61	2,050,600.69
TOTAL ACCOMODATIONS	49,308,691.00	5,210,738.00
TOTAL CHARGES	154,940,235.61	7,261,338.69

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,019,888.68	ADJUSTMENTS	0.00
COVERED CHARGES	18,162,964.68	CONTRACTUAL ALLOW	8,867,157.29
NON-COVERD CHARGES	856,924.00	TOTAL MEDICAID LIAB	9,295,807.39
		LESS: COB	9,295,807.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 147

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	363	0	448,081.00	49,483.00
ROUTINE NURSERY	1,195	0	4,317,091.00	748,130.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,558	0	4,765,172.00	797,613.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	75	0	293,878.00	0.00
NICU	752	0	4,815,531.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	827	0	5,109,409.00	0.00
TOTAL ACCOMODATIONS	2,385	0	9,874,581.00	797,613.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,577,767.60	0.00	OTHER LAB	117,094.00	0.00
MED/SURG SUPPLY	466,903.00	414.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,222,288.08	0.00	EDUCATION & TRAINING	2,000.00	0.00
RADIOLOGY-DIAGNOSTIC	358,345.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,832.00
CT SCAN	65,398.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	85,362.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,464.00	0.00	MRI SERVICES	24,092.00	0.00
IV THERAPY	1,770.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	404,044.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	319,437.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,302,401.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,673.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,026.00	0.00	SPECIAL SERVICES	0.00	56,065.00
RECOVERY ROOM	71,655.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	21,095.00	0.00	INJECTABLE DRUGS	603,075.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	151,872.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	66,359.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	440.00	0.00	IMPL DEV CHARGE PATIENTS	5,018.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,109.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	125,897.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	39,031.00	0.00			
CARDIOLOGY	128,225.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,543.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,288,383.68	59,311.00
TOTAL ACCOMODATIONS	9,874,581.00	797,613.00
TOTAL CHARGES	18,162,964.68	856,924.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,688,603.57	ADJUSTMENTS	2,462,526.31
COVERED CHARGES	38,087,776.06	CONTRACTUAL ALLOW	30,291,394.56
NON-COVERD CHARGES	3,600,827.51	TOTAL MEDICAID LIAB	7,796,381.50
		LESS: COB	54,278.29
		LESS: COPAYMENT	25,992.40
		REIMBURSEMENT	7,716,110.81
		ALL OTHER	5,434,220.43
		FEE SCHEDULE-LAB	725,535.48
		INJECTABLE DRUGS	1,556,354.90

TOTAL NUMBER OF CLAIMS 10,295

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	482,757.24	6,613.17	OTHER LAB	200,493.00	542.00
MED/SURG SUPPLY	499,535.63	8,111.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	744.00	EDUCATION & TRAINING	3,471.00	620.00
RADIOLOGY-DIAGNOSTIC	569,472.00	5,038.00	OTHER THERAPEUTIC SVC	0.00	7,704.00
CT SCAN	2,996,334.00	499,621.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,927.00	18,465.00	FEE SCHEDULE LAB	11,457,414.21	489,207.20
EKG/ECG	198,972.00	1,840.00	MRI SERVICES	2,534,169.00	143,575.00
IV THERAPY	3,155,920.00	118,385.00	PROFESSIONAL FEES	0.00	2,496.00
OPERATING ROOM	2,593,152.00	339,409.00	DURABLE MED. EQUIP.	0.00	4,227.00
LABOR/DELIVERY ROOM	157,483.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,697.00	5,976.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	668,674.00	931.00	AMBULANCE	0.00	0.00
GI SERVICES	52,326.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,599,281.00	60,046.00	SPECIAL SERVICES	0.00	358.00
RECOVERY ROOM	423,910.00	377.00	DRUG-SPECIFIC/HOME IV	0.00	1,404.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,535,297.90	1,159,749.89
RADIOLOGY THERAPEUTIC	1,529,316.00	6,527.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,626.00	14,312.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,037.00	5,606.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	74,617.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	748,500.00	85,126.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	88,711.00	25,909.00	IMPL DEV CHARGE PATIENTS	191,838.00	6,844.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,747,281.00	322,428.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	903,841.72	13,398.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,450.00	17,789.00			
AUDIOLOGY	3,994.00	0.00			
CARDIOLOGY	121,869.00	70,640.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,460.00	0.00			
ORGAN ACQUISITION	0.00	77,277.00			
TREATMENT/OBSERV. RM	352,566.36	4,915.00			

TOTAL ANCILLARY	38,087,776.06	3,600,827.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,087,776.06	3,600,827.51

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,462,208.14	ADJUSTMENTS	0.00
COVERED CHARGES	914,107.24	CONTRACTUAL ALLOW	336,925.88
NON-COVERD CHARGES	548,100.90	TOTAL MEDICAID LIAB	577,181.36
		LESS: COB	576,851.36
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 246

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,562.07	0.00	OTHER LAB	8,755.00	0.00
MED/SURG SUPPLY	24,181.00	390.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,771.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,491.00	861.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,760.00	37,942.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,200.00	FEE SCHEDULE LAB	192,695.00	14,380.00
EKG/ECG	4,784.00	368.00	MRI SERVICES	15,828.00	5,276.00
IV THERAPY	49,169.00	3,687.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,314.00	150,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,752.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,078.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,021.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,021.00	4,804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,517.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	103,891.17	270,071.90
RADIOLOGY THERAPEUTIC	7,701.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	832.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,897.00	1,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,347.00	0.00	IMPL DEV CHARGE PATIENTS	18,473.00	12,878.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,500.00	41,307.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,943.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	215.00	117.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,212.00	0.00			

TOTAL ANCILLARY	914,107.24	548,100.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	914,107.24	548,100.90

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

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	367,578.41	ADJUSTMENTS	2,827.12
COVERED CHARGES	342,336.09	CONTRACTUAL ALLOW	335,298.77
NON-COVERD CHARGES	25,242.32	TOTAL MEDICAID LIAB	7,037.32
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	6,812.32
		TOTAL NUMBER OF CLAIMS	119

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,706.42	0.00	OTHER LAB	2,652.00	0.00
MED/SURG SUPPLY	6,478.00	174.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,146.00	561.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,284.00	6,266.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,836.00	702.00
EKG/ECG	6,274.00	0.00	MRI SERVICES	0.00	5,276.00
IV THERAPY	1,499.00	982.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,411.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,227.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	163,248.00	3,943.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	935.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,126.67	2,489.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,479.00	4,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,034.00	0.00			

TOTAL ANCILLARY	342,336.09	25,242.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,336.09	25,242.32

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,430.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,383.00	CONTRACTUAL ALLOW	19,685.81
NON-COVERD CHARGES	12,047.50	TOTAL MEDICAID LIAB	9,697.19
		LESS: COB	9,697.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,227.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.00	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	5,663.00	0.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	8,198.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,243.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,200.00	1,588.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,051.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,969.50	1,319.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,258.00	942.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,383.00	12,047.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,383.00	12,047.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,609,744.35	ADJUSTMENTS	705,902.46
COVERED CHARGES	8,219,691.92	CONTRACTUAL ALLOW	6,228,607.76
NON-COVERD CHARGES	390,052.43	TOTAL MEDICAID LIAB	1,991,084.16
		LESS: COB	2,729.45
		LESS: COPAYMENT	2,463.00
		REIMBURSEMENT	1,985,891.71

TOTAL NUMBER OF CLAIMS 360

GEORGIA 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,164.56	2,438.00	OTHER LAB	3,320.00	0.00
MED/SURG SUPPLY	268,263.98	1,065.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,669.00	37,771.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,786.00	19,965.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,470.00	FEE SCHEDULE LAB	686,991.00	55,008.00
EKG/ECG	10,394.00	482.00	MRI SERVICES	14,843.00	0.00
IV THERAPY	793,470.00	12,548.00	PROFESSIONAL FEES	0.00	390.00
OPERATING ROOM	866,307.00	66,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,810.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	134,691.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,436.00	530.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,348,341.78	111,806.43
RADIOLOGY THERAPEUTIC	639,386.00	9,767.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,372.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,047.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,609.00	12,384.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	645,347.00	17,034.00
LITHOTRIPSY	93,408.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,866.00	707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,349.00	1,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,082.00	1,964.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	86,093.00	22,689.00			
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	40,476.60	8,087.00			

TOTAL ANCILLARY	8,219,691.92	390,052.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,219,691.92	390,052.43

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	803,133.55	ADJUSTMENTS	0.00
COVERED CHARGES	700,770.85	CONTRACTUAL ALLOW	349,502.65
NON-COVERD CHARGES	102,362.70	TOTAL MEDICAID LIAB	351,268.20
		LESS: COB	351,151.20
		LESS: COPAYMENT	117.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,169.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,369.00	95.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	822.00	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	3,508.00	FEE SCHEDULE LAB	37,478.00	1,934.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,186.00	390.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,023.00	64,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,021.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,023.00	931.00	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	11,748.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	358,376.95	16,829.70
RADIOLOGY THERAPEUTIC	59,948.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,622.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	965.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,257.00	12,959.00
LITHOTRIPSY	23,352.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,664.00	0.00			

TOTAL ANCILLARY	700,770.85	102,362.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	700,770.85	102,362.70

** 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,177,456.63	ADJUSTMENTS	9,410.84
COVERED CHARGES	3,897,304.35	CONTRACTUAL ALLOW	2,842,483.30
NON-COVERD CHARGES	280,152.28	TOTAL MEDICAID LIAB	1,054,821.05
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,054,821.05

TOTAL NUMBER OF ADMISSIONS 126

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	972	0	637,412.00	259,836.00
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	972	0	637,412.00	259,836.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	12,915.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	12,915.00	0.00
TOTAL ACCOMODATIONS	979	0	650,327.00	259,836.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	928,429.14	0.00	OTHER LAB	35,373.00	0.00
MED/SURG SUPPLY	225,607.79	252.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	382,982.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,074.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	233,182.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	224,296.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,488.00	0.00	MRI SERVICES	73,369.00	0.00
IV THERAPY	21,853.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	148,749.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,997.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,672.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	213,373.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,230.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,329.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	238,236.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	70,506.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	112.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,206.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,049.00
OTHER IMAGING SERVICE	23,295.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,551.00	16,753.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	22,264.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,013.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,838.00	150.00			

TOTAL ANCILLARY	3,246,977.35	20,316.28
TOTAL ACCOMODATIONS	650,327.00	259,836.00
TOTAL CHARGES	3,897,304.35	280,152.28

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 08/01/17 THROUGH 07/31/18
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	2019007031088	03/14/18 - 03/16/18	01/14/19	0.00	3,049.00	0.00	0.00	0.00
TOTAL				0.00	3,049.00	0.00	0.00	0.00

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,881,386.78	ADJUSTMENTS	49,812.98
COVERED CHARGES	1,688,717.39	CONTRACTUAL ALLOW	1,315,470.52
NON-COVERD CHARGES	192,669.39	TOTAL MEDICAID LIAB	373,246.87
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	372,829.87
		ALL OTHER	355,943.93
		FEE SCHEDULE-LAB	14,144.58
		INJECTABLE DRUGS	2,741.36

TOTAL NUMBER OF CLAIMS 376

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,805.23	141.00	OTHER LAB	1,278.00	0.00
MED/SURG SUPPLY	66,058.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,187.00	666.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	493,450.00	75,605.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,937.00	4,791.00
EKG/ECG	8,729.00	0.00	MRI SERVICES	4,947.00	2,583.00
IV THERAPY	14,709.00	2,832.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	401,747.00	76,846.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,248.00	3,511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,928.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291,340.00	8,752.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,845.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97,614.45	10,152.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,049.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,786.00	5,522.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,034.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,865.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,539.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,763.00	1,166.00			

TOTAL ANCILLARY	1,688,717.39	192,669.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,688,717.39	192,669.39

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,209.94	ADJUSTMENTS	0.00
COVERED CHARGES	11,653.94	CONTRACTUAL ALLOW	3,930.05
NON-COVERD CHARGES	1,556.00	TOTAL MEDICAID LIAB	7,723.89
		LESS: COB	7,717.89
		LESS: COPAYMENT	6.00
		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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 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	195.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,757.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	316.00	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	1,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,149.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	630.00	1,556.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,653.94	1,556.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,653.94	1,556.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,577.32	ADJUSTMENTS	55.94
COVERED CHARGES	22,995.32	CONTRACTUAL ALLOW	22,379.98
NON-COVERD CHARGES	12,582.00	TOTAL MEDICAID LIAB	615.34
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	594.34
		TOTAL NUMBER OF CLAIMS	11

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	631.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,427.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	12,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,613.00	145.00
EKG/ECG	406.00	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	132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,127.00	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	1,641.00	67.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,126.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	586.00	0.00			

TOTAL ANCILLARY	22,995.32	12,582.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,995.32	12,582.00

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 NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	731,602.45	ADJUSTMENTS	11,435.36
COVERED CHARGES	727,614.65	CONTRACTUAL ALLOW	596,004.51
NON-COVERD CHARGES	3,987.80	TOTAL MEDICAID LIAB	131,610.14
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	131,541.14
		TOTAL NUMBER OF CLAIMS	23

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,540.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,123.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,830.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,225.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	589.00	1,575.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	497,673.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,544.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,014.00	225.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,401.30	2,187.80
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	100,146.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,387.00	0.00			

TOTAL ANCILLARY	727,614.65	3,987.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	727,614.65	3,987.80

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	240,149.42	ADJUSTMENTS	0.00
COVERED CHARGES	236,267.42	CONTRACTUAL ALLOW	113,929.97
NON-COVERD CHARGES	3,882.00	TOTAL MEDICAID LIAB	122,337.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	122,337.45

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	40,150.00	1,288.00
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	72	0	40,150.00	1,288.00
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	72	0	40,150.00	1,288.00

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,217.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,746.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,472.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,423.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,065.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,225.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,750.00	0.00	PROFESSIONAL FEES	0.00	2,594.00
OPERATING ROOM	2,207.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,618.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	661.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,367.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	349.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,316.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	216.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	373.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,364.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,550.00	0.00			

TOTAL ANCILLARY	196,117.42	2,594.00
TOTAL ACCOMODATIONS	40,150.00	1,288.00
TOTAL CHARGES	236,267.42	3,882.00

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	992,465.77	ADJUSTMENTS	13,645.25
COVERED CHARGES	942,069.35	CONTRACTUAL ALLOW	680,918.52
NON-COVERD CHARGES	50,396.42	TOTAL MEDICAID LIAB	261,150.83
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	260,895.83
		ALL OTHER	228,657.77
		FEE SCHEDULE-LAB	25,922.37
		INJECTABLE DRUGS	6,315.69

TOTAL NUMBER OF CLAIMS 759

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,756.68	68.00	OTHER LAB	3,056.00	994.00
MED/SURG SUPPLY	36,377.00	189.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,570.00	6,347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	126,294.00	2,969.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,038.00	0.00	FEE SCHEDULE LAB	248,282.00	16,252.00
EKG/ECG	32,459.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,923.00	153.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,129.00	1,533.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,912.00	3,459.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,114.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,527.00	10,284.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,869.67	90.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,734.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	272.00	253.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,298.00	0.00	IMPL DEV CHARGE PATIENTS	584.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,520.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,942.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,332.00	7,805.00			

TOTAL ANCILLARY	942,069.35	50,396.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	942,069.35	50,396.42

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,349.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,197.00	CONTRACTUAL ALLOW	764.44
NON-COVERD CHARGES	152.00	TOTAL MEDICAID LIAB	1,432.56
		LESS: COB	1,432.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.00	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	932.00	152.00
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	1,224.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,197.00	152.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,197.00	152.00

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,865.84	ADJUSTMENTS	0.00
COVERED CHARGES	17,261.84	CONTRACTUAL ALLOW	16,175.84
NON-COVERD CHARGES	604.00	TOTAL MEDICAID LIAB	1,086.00
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	1,074.00
		TOTAL NUMBER OF CLAIMS	23

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	611.84	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	795.00	188.00	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	2,958.00	416.00
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	12,690.00	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	207.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,261.84	604.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,261.84	604.00

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,105,254.33	ADJUSTMENTS	139,454.85
COVERED CHARGES	17,038,800.56	CONTRACTUAL ALLOW	13,611,906.78
NON-COVERD CHARGES	66,453.77	TOTAL MEDICAID LIAB	3,426,893.78
		LESS: COB	3,359.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,423,534.42

TOTAL NUMBER OF ADMISSIONS 414

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,033	0	1,334,636.00	57,983.00
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	1,033	0	1,334,636.00	57,983.00
SPECIAL CARE SERVICES				
CCU	541	0	1,360,074.00	0.00
ICU	194	0	696,654.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	735	0	2,056,728.00	0.00
TOTAL ACCOMODATIONS	1,768	0	3,391,364.00	57,983.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,610,554.10	0.00	OTHER LAB	124,848.00	0.00
MED/SURG SUPPLY	495,778.26	1,254.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,517,397.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	387,258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,631,586.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,487.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	244,759.00	0.00	MRI SERVICES	311,241.00	0.00
IV THERAPY	403,152.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	628,566.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,577,948.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	334,026.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,554.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,138,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,009.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	82,015.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	51,040.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,162.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,860.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	197,604.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,664.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	10,805.00	0.00	IMPL DEV CHARGE PATIENTS	115,485.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	785.00
OTHER IMAGING SERVICE	120,388.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,821.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	218,408.00	443.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	830,157.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,768.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	212,758.46	0.00			

TOTAL ANCILLARY	13,647,436.56	8,470.77
TOTAL ACCOMODATIONS	3,391,364.00	57,983.00
TOTAL CHARGES	17,038,800.56	66,453.77

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 07/01/17 THROUGH 06/30/18
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	2018022012609	01/06/18 - 01/07/18	01/29/18	0.00	157.00	0.00	0.00	0.00
780	2018068049439	01/23/18 - 01/28/18	03/12/18	0.00	157.00	0.00	0.00	0.00
780	2018110050036	04/09/18 - 04/12/18	04/23/18	0.00	157.00	0.00	0.00	0.00
780	2018151063802	05/12/18 - 05/13/18	06/04/18	0.00	157.00	0.00	0.00	0.00
780	2018156046258	05/15/18 - 05/15/18	06/11/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	785.00	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,244.27	ADJUSTMENTS	0.00
COVERED CHARGES	60,572.27	CONTRACTUAL ALLOW	7,240.64
NON-COVERD CHARGES	672.00	TOTAL MEDICAID LIAB	53,331.63
		LESS: COB	53,331.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12	0	15,504.00	672.00
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	15,504.00	672.00
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	15,504.00	672.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,208.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,028.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,302.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,090.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,385.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,447.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	512.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,224.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,616.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,456.50	0.00			

TOTAL ANCILLARY	45,068.27	0.00
TOTAL ACCOMODATIONS	15,504.00	672.00
TOTAL CHARGES	60,572.27	672.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,320,236.97	ADJUSTMENTS	316,050.82
COVERED CHARGES	13,318,974.85	CONTRACTUAL ALLOW	11,786,150.17
NON-COVERD CHARGES	1,001,262.12	TOTAL MEDICAID LIAB	1,532,824.68
		LESS: COB	31,682.37
		LESS: COPAYMENT	2,302.73
		REIMBURSEMENT	1,498,839.58
		ALL OTHER	1,378,497.28
		FEE SCHEDULE-LAB	89,392.98
		INJECTABLE DRUGS	30,949.32

TOTAL NUMBER OF CLAIMS 2,892

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	411,165.43	330.00	OTHER LAB	168,462.00	1,990.00
MED/SURG SUPPLY	139,806.37	4,509.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802,292.00	7,173.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,653,967.00	236,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,637.00	10,851.15	FEE SCHEDULE LAB	1,756,656.00	81,573.00
EKG/ECG	240,170.00	1,536.00	MRI SERVICES	530,097.00	50,473.00
IV THERAPY	776,690.00	44,948.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	461,830.75	85,131.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,768.00	61,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	261,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,863.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,304,120.00	10,096.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144,828.75	95,501.75
RADIOLOGY THERAPEUTIC	313,511.00	907.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,639.00	1,714.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	29,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,601.00	4,515.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,439.00	45,579.00	IMPL DEV CHARGE PATIENTS	28,833.45	2,205.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	462.00	400.00
OTHER IMAGING SERVICE	307,761.00	64,117.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	188,894.00	25,404.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	234,606.00	128,031.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	137,938.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	180,316.10	6,686.00			

TOTAL ANCILLARY	13,318,974.85	1,001,262.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,318,974.85	1,001,262.12

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 07/01/17 THROUGH 06/30/18
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	5918032001218	12/20/17 - 12/20/17	02/05/18	77.00	0.00	0.00	0.00	20.52
780	5918032001218	12/20/17 - 12/20/17	02/05/18	0.00	80.00	0.00	0.00	0.00
780	2018088060035	03/11/18 - 03/11/18	04/02/18	77.00	0.00	0.00	0.00	20.52
780	2018088060035	03/11/18 - 03/11/18	04/02/18	0.00	80.00	0.00	0.00	0.00
780	5918130000704	04/09/18 - 04/09/18	05/14/18	77.00	0.00	0.00	0.00	20.52
780	5918130000704	04/09/18 - 04/09/18	05/14/18	0.00	80.00	0.00	0.00	0.00
780	2018148005348	05/12/18 - 05/12/18	06/04/18	77.00	0.00	0.00	0.00	20.52
780	5918173000613	03/19/18 - 03/19/18	06/25/18	77.00	0.00	0.00	0.00	20.52
780	5918173000613	03/19/18 - 03/19/18	06/25/18	0.00	80.00	0.00	0.00	0.00
780	2018226060911	04/25/18 - 04/25/18	08/20/18	77.00	0.00	0.00	0.00	20.52
780	2018226060911	04/25/18 - 04/25/18	08/20/18	0.00	80.00	0.00	0.00	0.00
TOTAL				462.00	400.00	0.00	0.00	123.12

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	462,499.13	ADJUSTMENTS	0.00
COVERED CHARGES	393,826.13	CONTRACTUAL ALLOW	249,106.43
NON-COVERD CHARGES	68,673.00	TOTAL MEDICAID LIAB	144,719.70
		LESS: COB	144,695.93
		LESS: COPAYMENT	23.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,147.25	1,426.25	OTHER LAB	7,228.00	0.00
MED/SURG SUPPLY	5,650.30	177.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,088.00	1,057.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,475.00	22,424.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,892.00	4,021.00
EKG/ECG	7,168.00	0.00	MRI SERVICES	4,678.00	9,228.00
IV THERAPY	43,114.00	888.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,686.00	7,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	2,673.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,805.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	118,635.00	2,520.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,418.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,560.00	864.75
RADIOLOGY THERAPEUTIC	232.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	3,620.00	IMPL DEV CHARGE PATIENTS	176.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	77.00	200.00
OTHER IMAGING SERVICE	17,035.00	9,349.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,642.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,737.10	474.00			

TOTAL ANCILLARY	393,826.13	68,673.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	393,826.13	68,673.00

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

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2018214057445	06/23/18 - 06/23/18	08/06/18	77.00	0.00	0.00	1,839.60	0.00
780	2018214057445	06/23/18 - 06/23/18	08/06/18	0.00	80.00	0.00	1,839.60	0.00
948	2018242054512	03/28/18 - 03/28/18	09/03/18	0.00	120.00	0.00	0.00	0.00
TOTAL				77.00	200.00	0.00	3,679.20	0.00

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	605,062.25	ADJUSTMENTS	376.58
COVERED CHARGES	560,403.50	CONTRACTUAL ALLOW	545,807.73
NON-COVERD CHARGES	44,658.75	TOTAL MEDICAID LIAB	14,595.77
		LESS: COB	2,344.91
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	11,974.86
		TOTAL NUMBER OF CLAIMS	219

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,429.50	0.00	OTHER LAB	8,128.00	0.00
MED/SURG SUPPLY	1,038.00	359.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,083.00	3,788.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,506.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,778.00	10,456.00
EKG/ECG	7,680.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,192.00	675.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,564.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	283,215.00	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	13,491.75
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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,238.00	11,638.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,552.00	4,140.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	560,403.50	44,658.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	560,403.50	44,658.75

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,244.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,574.00	CONTRACTUAL ALLOW	35,005.09
NON-COVERD CHARGES	1,670.00	TOTAL MEDICAID LIAB	5,568.91
		LESS: COB	5,553.91
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261.00	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	1,826.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,653.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,120.00	558.00
EKG/ECG	1,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	948.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,883.00	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	1,112.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	859.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,574.00	1,670.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,574.00	1,670.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,169,038.83	ADJUSTMENTS	43,586.40
COVERED CHARGES	1,026,708.71	CONTRACTUAL ALLOW	939,343.91
NON-COVERD CHARGES	142,330.12	TOTAL MEDICAID LIAB	87,364.80
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	87,145.80
		TOTAL NUMBER OF CLAIMS	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,414.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,474.96	47.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	445.00	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	1,071.00	FEE SCHEDULE LAB	2,327.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,962.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,265.00	3,413.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,569.00	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	8,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	552,367.50	115,047.00
RADIOLOGY THERAPEUTIC	350,482.00	11,360.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,837.00	11,391.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	1,026,708.71	142,330.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,026,708.71	142,330.12

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

THE MEDICAL CENTER 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	660,442.52	ADJUSTMENTS	22,656.77
COVERED CHARGES	659,801.52	CONTRACTUAL ALLOW	334,924.68
NON-COVERD CHARGES	641.00	TOTAL MEDICAID LIAB	324,876.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	324,876.84

TOTAL NUMBER OF ADMISSIONS 60

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	225	0	156,375.00	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	225	0	156,375.00	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	225	0	156,375.00	0.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,846.93	0.00	OTHER LAB	3,746.00	0.00
MED/SURG SUPPLY	32,727.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,245.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,838.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,482.00	641.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	843.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,882.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,285.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,564.00	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	59,410.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	738.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,373.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,412.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,722.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,931.00	0.00			

TOTAL ANCILLARY	503,426.52	641.00
TOTAL ACCOMODATIONS	156,375.00	0.00
TOTAL CHARGES	659,801.52	641.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,509.89	ADJUSTMENTS	0.00
COVERED CHARGES	10,509.89	CONTRACTUAL ALLOW	4,212.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,297.52
		LESS: COB	6,297.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	3,475.00	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	3,475.00	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	0	3,475.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,304.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	656.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,172.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	189.00	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	111.00	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	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	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	515.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,287.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,034.89	0.00
TOTAL ACCOMODATIONS	3,475.00	0.00
TOTAL CHARGES	10,509.89	0.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,348,310.89	ADJUSTMENTS	95,630.62
COVERED CHARGES	2,175,156.61	CONTRACTUAL ALLOW	1,653,078.75
NON-COVERD CHARGES	173,154.28	TOTAL MEDICAID LIAB	522,077.86
		LESS: COB	2,819.09
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	518,181.77
		ALL OTHER	445,745.30
		FEE SCHEDULE-LAB	69,437.20
		INJECTABLE DRUGS	2,999.27

TOTAL NUMBER OF CLAIMS 1,738

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,394.84	427.14	OTHER LAB	143,793.00	0.00
MED/SURG SUPPLY	14,563.71	1,384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	103,191.00	5,851.00	OTHER THERAPEUTIC SVC	0.00	588.00
CT SCAN	290,570.00	54,645.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,082.00	268.00	FEE SCHEDULE LAB	558,633.30	17,614.00
EKG/ECG	26,196.00	555.00	MRI SERVICES	1,656.00	0.00
IV THERAPY	130,829.00	25,834.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,738.34	40,812.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,326.00	6,141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	444,776.50	3,189.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,114.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,108.92	7,323.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	380.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	392.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	208.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,226.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,599.00	5,223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,111.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,118.00	251.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,287.00	1,287.00			
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	51,145.00	142.00			

TOTAL ANCILLARY	2,175,156.61	173,154.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,175,156.61	173,154.28

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,145.19	ADJUSTMENTS	0.00
COVERED CHARGES	17,995.81	CONTRACTUAL ALLOW	6,472.42
NON-COVERD CHARGES	3,149.38	TOTAL MEDICAID LIAB	11,523.39
		LESS: COB	11,521.90
		LESS: COPAYMENT	1.49
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303.59	0.00	OTHER LAB	3,762.00	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	232.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,514.00	2,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,081.00	0.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	764.00	124.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,612.00	22.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	480.22	273.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,995.81	3,149.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,995.81	3,149.38

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	144,762.24	ADJUSTMENTS	3,506.00
COVERED CHARGES	136,447.44	CONTRACTUAL ALLOW	126,087.44
NON-COVERD CHARGES	8,314.80	TOTAL MEDICAID LIAB	10,360.00
		LESS: COB	0.00
		LESS: COPAYMENT	405.00
		REIMBURSEMENT	9,955.00
		TOTAL NUMBER OF CLAIMS	186

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,541.00	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	4,922.00	1,041.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,213.00	5,741.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,032.00	395.00
EKG/ECG	1,110.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,952.00	248.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	746.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,662.00	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	1,879.44	143.80
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	136,447.44	8,314.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,447.44	8,314.80

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,290.79	ADJUSTMENTS	0.00
COVERED CHARGES	2,290.79	CONTRACTUAL ALLOW	1,842.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	447.96
		LESS: COB	447.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330.23	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	415.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	231.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	954.00	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	360.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,290.79	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,290.79	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,359.09	ADJUSTMENTS	0.00
COVERED CHARGES	23,768.37	CONTRACTUAL ALLOW	18,905.48
NON-COVERD CHARGES	590.72	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,256.00	146.00	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	51.00	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	19,908.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	866.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	427.94	444.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,768.37	590.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,768.37	590.72

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,251,522.84	ADJUSTMENTS	124,085.90
COVERED CHARGES	1,203,944.84	CONTRACTUAL ALLOW	644,891.26
NON-COVERD CHARGES	47,578.00	TOTAL MEDICAID LIAB	559,053.58
		LESS: COB	6,110.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	552,943.16

TOTAL NUMBER OF ADMISSIONS 69

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	277	0	282,815.00	44,045.00
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	277	0	282,815.00	44,045.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	41	0	102,500.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	102,500.00	0.00
TOTAL ACCOMODATIONS	318	0	385,315.00	44,045.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,000.17	0.00	OTHER LAB	3,748.00	0.00
MED/SURG SUPPLY	10,170.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	97,836.22	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,968.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,500.00	1,533.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,080.78	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,714.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,572.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123,319.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,050.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,966.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,552.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,497.76	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	3,377.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	526.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,906.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,000.00
OTHER IMAGING SERVICE	4,245.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,067.97	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,267.63	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,262.50	0.00			

TOTAL ANCILLARY	818,629.84	3,533.00
TOTAL ACCOMODATIONS	385,315.00	44,045.00
TOTAL CHARGES	1,203,944.84	47,578.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2018333069023	11/14/18 - 11/21/18	12/03/18	0.00	1,000.00	0.00	0.00	0.00
618	2319064000133	09/19/18 - 09/24/18	03/25/19	0.00	1,000.00	0.00	719.65	0.00
TOTAL				0.00	2,000.00	0.00	719.65	0.00

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,504,020.99	ADJUSTMENTS	66,566.96
COVERED CHARGES	2,432,490.27	CONTRACTUAL ALLOW	2,008,538.57
NON-COVERD CHARGES	71,530.72	TOTAL MEDICAID LIAB	423,951.70
		LESS: COB	647.12
		LESS: COPAYMENT	999.36
		REIMBURSEMENT	422,305.22
		ALL OTHER	357,006.77
		FEE SCHEDULE-LAB	47,195.40
		INJECTABLE DRUGS	18,103.05

TOTAL NUMBER OF CLAIMS 1,188

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,342.43	476.16	OTHER LAB	102,396.00	0.00
MED/SURG SUPPLY	11,200.80	12.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,794.56	522.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,250.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	168,722.97	15,387.33
EKG/ECG	57,169.00	0.00	MRI SERVICES	15,000.00	0.00
IV THERAPY	30,904.50	5,943.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	193,604.35	20,425.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,360.50	3,055.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,419,664.14	3,174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,770.17	10,166.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	508.02	254.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,302.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,301.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,545.82	4,044.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	515.09	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,818.64	2,266.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,165.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,824.50	0.00			

TOTAL ANCILLARY	2,432,490.27	71,530.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,432,490.27	71,530.72

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,759.97	ADJUSTMENTS	0.00
COVERED CHARGES	32,055.31	CONTRACTUAL ALLOW	17,102.01
NON-COVERD CHARGES	4,704.66	TOTAL MEDICAID LIAB	14,953.30
		LESS: COB	14,942.27
		LESS: COPAYMENT	11.03
		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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	88.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,710.28	870.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	2,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,000.70	241.56
EKG/ECG	1,192.00	0.00	MRI SERVICES	0.00	1,000.00
IV THERAPY	444.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,562.50	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	3,869.01	9.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,233.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,055.31	4,704.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,055.31	4,704.66

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,798.65	ADJUSTMENTS	639.92
COVERED CHARGES	45,542.99	CONTRACTUAL ALLOW	44,077.34
NON-COVERD CHARGES	255.66	TOTAL MEDICAID LIAB	1,465.65
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	1,432.65
		TOTAL NUMBER OF CLAIMS	24

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.20	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	1,203.34	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	1,698.45	237.36
EKG/ECG	1,192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,166.00	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	102.00	18.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	45,542.99	255.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,542.99	255.66

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,020.38	ADJUSTMENTS	0.00
COVERED CHARGES	11,582.02	CONTRACTUAL ALLOW	7,191.02
NON-COVERD CHARGES	2,438.36	TOTAL MEDICAID LIAB	4,391.00
		LESS: COB	4,382.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	332.84	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	348.20	348.20	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	350.13	55.41
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,302.00	1,700.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	320.01	1.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	332.84	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,582.02	2,438.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,582.02	2,438.36

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	71,037,540.18	ADJUSTMENTS	2,013,441.04
COVERED CHARGES	69,031,873.80	CONTRACTUAL ALLOW	48,027,857.32
NON-COVERD CHARGES	2,005,666.38	TOTAL MEDICAID LIAB	21,004,016.48
		LESS: COB	227,612.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,776,404.34

TOTAL NUMBER OF ADMISSIONS 1,888

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9,196	0	6,030,861.00	1,056,921.00
ROUTINE NURSERY	636	0	419,158.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	16,510.38
TOTAL ROUTINE	9,832	0	6,450,019.00	1,073,431.38
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,160	0	2,168,570.00	0.00
NICU	669	0	1,374,328.00	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	1,829	0	3,542,898.00	0.00
TOTAL ACCOMODATIONS	11,661	0	9,992,917.00	1,073,431.38

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,229,817.12	1,558.93	OTHER LAB	414,708.00	0.00
MED/SURG SUPPLY	6,404,498.34	105,470.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,507,226.88	16,897.70	EDUCATION & TRAINING	77.00	0.00
RADIOLOGY-DIAGNOSTIC	1,330,411.00	0.00	OTHER THERAPEUTIC SVC	0.00	42,186.00
CT SCAN	2,536,230.00	51,878.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	676,301.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	358,508.00	0.00	MRI SERVICES	637,457.00	0.00
IV THERAPY	335,105.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,659,181.00	93,899.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	272,236.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,149,937.00	2,400.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,508,566.50	396.00	AMBULANCE	0.00	0.00
GI SERVICES	201,240.00	5,418.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,420,003.00	472.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,188,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	225,838.00	0.00	INJECTABLE DRUGS	1,663.00	0.00
RADIOLOGY THERAPEUTIC	474,140.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	409,807.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	145,446.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60.00	13,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	260,124.00	0.00	IMPL DEV CHARGE PATIENTS	3,747,376.96	3,527.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	34,105.06
OTHER IMAGING SERVICE	378,790.00	5,426.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	514,630.00	538,365.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	168,613.00	0.00			
AUDIOLOGY	73,577.00	0.00			
CARDIOLOGY	2,484,779.00	3,100.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,338.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,277,672.00	14,129.00			

TOTAL ANCILLARY	59,038,956.80	932,235.00
TOTAL ACCOMODATIONS	9,992,917.00	1,073,431.38
TOTAL CHARGES	69,031,873.80	2,005,666.38

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 08/01/17 THROUGH 07/31/18
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	2017272073266	09/16/17 - 09/19/17	10/09/17	0.00	3,049.00	0.00	0.00	0.00
615	2017303032119	10/09/17 - 10/24/17	11/06/17	0.00	3,049.00	0.00	0.00	0.00
615	2017338041708	11/24/17 - 11/27/17	12/11/17	0.00	3,049.00	0.00	0.00	0.00
615	2017338041724	11/23/17 - 11/29/17	12/11/17	0.00	3,049.00	0.00	0.00	0.00
615	2118040000007	10/21/17 - 10/26/17	02/26/18	0.00	3,049.00	0.00	2,087.12	0.00
615	2018064035719	01/17/18 - 02/10/18	03/12/18	0.00	3,049.00	0.00	0.00	0.00
615	2018107074531	04/05/18 - 04/06/18	04/23/18	0.00	3,049.00	0.00	0.00	0.00
615	2018309043720	03/07/18 - 03/11/18	11/12/18	0.00	3,049.00	0.00	0.00	0.00
615	2218324001835	02/25/18 - 04/03/18	11/26/18	0.00	3,049.00	0.00	0.00	0.00
284	2218331006887	06/27/18 - 06/30/18	12/03/18	0.00	566.06	0.00	0.00	0.00
615	2019075001632	12/15/17 - 12/28/17	03/25/19	0.00	3,049.00	0.00	0.00	0.00
615	2019225090240	11/26/17 - 12/11/17	08/19/19	0.00	3,049.00	0.00	0.00	0.00
TOTAL				0.00	34,105.06	0.00	2,087.12	0.00

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	136,616.79	ADJUSTMENTS	0.00
COVERED CHARGES	134,085.79	CONTRACTUAL ALLOW	41,359.07
NON-COVERD CHARGES	2,531.00	TOTAL MEDICAID LIAB	92,726.72
		LESS: COB	92,726.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	49	0	32,127.00	1,423.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	49	0	32,127.00	1,423.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	49	0	32,127.00	1,423.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,180.61	0.00	OTHER LAB	3,265.00	0.00
MED/SURG SUPPLY	10,396.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,998.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,305.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	406.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,511.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,825.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,302.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,095.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,895.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,023.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	750.00	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	714.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	339.00	1,108.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,144.00	0.00			

TOTAL ANCILLARY	101,958.79	1,108.00
TOTAL ACCOMODATIONS	32,127.00	1,423.00
TOTAL CHARGES	134,085.79	2,531.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,824,580.75	ADJUSTMENTS	1,398,111.06
COVERED CHARGES	32,793,988.78	CONTRACTUAL ALLOW	25,421,106.08
NON-COVERD CHARGES	4,030,591.97	TOTAL MEDICAID LIAB	7,372,882.70
		LESS: COB	8,557.22
		LESS: COPAYMENT	25,827.61
		REIMBURSEMENT	7,338,497.87
		ALL OTHER	5,684,256.70
		FEE SCHEDULE-LAB	601,608.63
		INJECTABLE DRUGS	1,052,632.54

TOTAL NUMBER OF CLAIMS 14,120

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,028,284.64	5,912.65	OTHER LAB	232,410.00	1,490.00
MED/SURG SUPPLY	1,690,027.65	698.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	496.00	EDUCATION & TRAINING	0.00	154.00
RADIOLOGY-DIAGNOSTIC	967,956.00	50,729.00	OTHER THERAPEUTIC SVC	0.00	1,488.00
CT SCAN	2,310,219.00	401,935.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,515.00	29,429.43	FEE SCHEDULE LAB	2,706,209.08	599,719.00
EKG/ECG	263,163.00	12,789.00	MRI SERVICES	792,589.00	60,809.00
IV THERAPY	1,042,479.00	102,039.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,449,486.73	359,133.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,632.00	0.00	REHAB THERAPY	0.00	1,940.00
RESPIRATORY SERVICES	173,543.00	45,884.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	904,248.00	6,048.00	AMBULANCE	0.00	0.00
GI SERVICES	680,399.55	223,778.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,448,800.00	147,940.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,349,709.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,832,671.84	1,035,760.06
RADIOLOGY THERAPEUTIC	1,555,263.00	329,954.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,401.00	3,065.17	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	35,594.00	22,038.82	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	263,466.00	43,467.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	34,821.00	114,389.00	IMPL DEV CHARGE PATIENTS	405,203.36	218.89
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,199.00
OTHER IMAGING SERVICE	808,337.00	57,974.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,541.00	93,625.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	603,258.00	40,728.00			
AUDIOLOGY	457.00	0.00			
CARDIOLOGY	642,478.50	112,649.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	477,904.00	3,891.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	811,922.43	115,221.00			

TOTAL ANCILLARY	32,793,988.78	4,030,591.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,793,988.78	4,030,591.97

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 08/01/17 THROUGH 07/31/18
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	2017269069521	09/19/17 - 09/19/17	10/02/17	0.00	2,608.00	0.00	0.00	0.00
9300	5918064000928	02/11/18 - 02/11/18	03/12/18	0.00	203.00	0.00	0.00	0.00
615	2018073000015	03/07/18 - 03/07/18	03/19/18	0.00	2,388.00	0.00	0.00	0.00
TOTAL				0.00	5,199.00	0.00	0.00	0.00

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

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	499,896.48	ADJUSTMENTS	0.00
COVERED CHARGES	307,760.90	CONTRACTUAL ALLOW	35,108.22
NON-COVERD CHARGES	192,135.58	TOTAL MEDICAID LIAB	272,652.68
		LESS: COB	272,326.54
		LESS: COPAYMENT	326.14
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 236

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,859.32	8.00	OTHER LAB	1,113.00	0.00
MED/SURG SUPPLY	17,354.62	254.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,145.00	7,271.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,479.00	8,459.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	22,820.00	FEE SCHEDULE LAB	22,676.75	8,841.00
EKG/ECG	2,513.00	203.00	MRI SERVICES	10,675.00	0.00
IV THERAPY	6,661.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,898.00	28,457.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	588.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,173.00	665.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,758.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,355.37	8,279.27
RADIOLOGY THERAPEUTIC	24,042.00	2,740.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,672.00	0.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	14,880.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,698.00	2,092.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,913.00	0.00	IMPL DEV CHARGE PATIENTS	7,546.84	1,700.00
LITHOTRIPSY	0.00	22,004.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,803.00	1,722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,718.00	3,324.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,582.00	10,182.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,674.00	48,084.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,940.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,838.00	150.00			

TOTAL ANCILLARY	307,760.90	192,135.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	307,760.90	192,135.58

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	325,331.63	ADJUSTMENTS	1,560.11
COVERED CHARGES	303,551.63	CONTRACTUAL ALLOW	290,942.71
NON-COVERD CHARGES	21,780.00	TOTAL MEDICAID LIAB	12,608.92
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	12,218.92

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,121.52	0.00	OTHER LAB	1,858.00	0.00
MED/SURG SUPPLY	10,593.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,493.00	1,044.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,666.00	6,603.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,549.00	2,478.00
EKG/ECG	5,075.00	0.00	MRI SERVICES	4,012.00	0.00
IV THERAPY	4,908.00	944.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,758.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,862.00	2,360.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,344.98	2,085.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	4,410.00	IMPL DEV CHARGE PATIENTS	1,313.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,351.00	748.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	678.00	1,108.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,491.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,568.00	0.00			

TOTAL ANCILLARY	303,551.63	21,780.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	303,551.63	21,780.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,892.32	ADJUSTMENTS	0.00
COVERED CHARGES	9,966.32	CONTRACTUAL ALLOW	2,629.41
NON-COVERD CHARGES	2,926.00	TOTAL MEDICAID LIAB	7,336.91
		LESS: COB	7,330.91
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	189.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,543.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,236.00	145.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,976.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.00	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	490.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	808.00	748.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,966.32	2,926.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,966.32	2,926.00

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,593,709.81	ADJUSTMENTS	468,508.16
COVERED CHARGES	13,024,524.51	CONTRACTUAL ALLOW	10,908,459.80
NON-COVERD CHARGES	569,185.30	TOTAL MEDICAID LIAB	2,116,064.71
		LESS: COB	9,129.10
		LESS: COPAYMENT	1,683.95
		REIMBURSEMENT	2,105,251.66

TOTAL NUMBER OF CLAIMS 369

GEORGIA 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232,634.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	542,272.39	358.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,027.00	32,904.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,830.00	1,893.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,445.00	1,610.11	FEE SCHEDULE LAB	103,680.00	8,966.00
EKG/ECG	12,992.00	4,669.00	MRI SERVICES	0.00	0.00
IV THERAPY	365,845.00	15,595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,368,677.10	128,014.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	721.00	428.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	366,987.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,659.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,759.00	674.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	303,829.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,877,949.17	279,052.18
RADIOLOGY THERAPEUTIC	215,951.32	7,362.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,430.00	1,807.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,918,123.36	0.00
LITHOTRIPSY	44,008.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,808.00	724.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	906.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,633.00	6,541.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	437,474.00	77,692.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,884.00	895.00			

TOTAL ANCILLARY	13,024,524.51	569,185.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,024,524.51	569,185.30

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	143,066.57	ADJUSTMENTS	0.00
COVERED CHARGES	74,771.57	CONTRACTUAL ALLOW	-34,769.79
NON-COVERD CHARGES	68,295.00	TOTAL MEDICAID LIAB	109,541.36
		LESS: COB	109,484.36
		LESS: COPAYMENT	57.00
		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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	570.00	143.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,376.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	405.00	27.00
EKG/ECG	203.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,179.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,273.00	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	3,305.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,117.00	0.00
RADIOLOGY THERAPEUTIC	44,038.00	18,250.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	49,875.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,771.57	68,295.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,771.57	68,295.00

** END OF REPORT **

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

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,289,025.45	ADJUSTMENTS	29,001.68
COVERED CHARGES	7,114,538.45	CONTRACTUAL ALLOW	5,399,965.28
NON-COVERD CHARGES	174,487.00	TOTAL MEDICAID LIAB	1,714,573.17
		LESS: COB	2,201.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,712,372.02

TOTAL NUMBER OF ADMISSIONS 255

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	592	0	690,272.00	130,172.00
ROUTINE NURSERY	88	0	86,883.00	1,188.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	1.00
TOTAL ROUTINE	680	0	777,155.00	131,361.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	136	0	539,723.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	136	0	539,723.00	0.00
TOTAL ACCOMODATIONS	816	0	1,316,878.00	131,361.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	824,326.52	0.00	OTHER LAB	100,868.00	0.00
MED/SURG SUPPLY	81,591.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,119,226.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	738,594.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,429.07	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	83,317.00	0.00	MRI SERVICES	96,749.00	0.00
IV THERAPY	53,192.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	332,193.00	0.00	DURABLE MED. EQUIP.	0.00	132.00
LABOR/DELIVERY ROOM	159,676.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,713.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	70,476.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	672,832.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,437.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	567.00	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	12,237.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	37,926.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,846.00	2,112.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	95,699.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,996.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,915.00	33,972.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,764.00	6,910.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	209,449.00	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	96,117.20	0.00			

TOTAL ANCILLARY	5,797,660.45	43,126.00
TOTAL ACCOMODATIONS	1,316,878.00	131,361.00
TOTAL CHARGES	7,114,538.45	174,487.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,769.86	ADJUSTMENTS	0.00
COVERED CHARGES	64,121.86	CONTRACTUAL ALLOW	48,773.85
NON-COVERD CHARGES	648.00	TOTAL MEDICAID LIAB	15,348.01
		LESS: COB	15,348.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	3,498.00	648.00
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	3,498.00	648.00
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	3,498.00	648.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,381.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,627.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	603.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	986.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,118.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,770.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,660.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,459.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,064.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,007.40	0.00			

TOTAL ANCILLARY	60,623.86	0.00
TOTAL ACCOMODATIONS	3,498.00	648.00
TOTAL CHARGES	64,121.86	648.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,309,126.06	ADJUSTMENTS	214,562.31
COVERED CHARGES	11,366,665.20	CONTRACTUAL ALLOW	10,099,403.78
NON-COVERD CHARGES	1,942,460.86	TOTAL MEDICAID LIAB	1,267,261.42
		LESS: COB	10,919.69
		LESS: COPAYMENT	2,317.83
		REIMBURSEMENT	1,254,023.90
		ALL OTHER	1,142,777.77
		FEE SCHEDULE-LAB	97,832.56
		INJECTABLE DRUGS	13,413.57

TOTAL NUMBER OF CLAIMS 2,710

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,073.94	0.00	OTHER LAB	181,331.00	0.00
MED/SURG SUPPLY	226,782.66	10,770.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	514,661.00	80,992.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,436,658.00	486,210.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,516.00	FEE SCHEDULE LAB	1,449,788.00	87,481.00
EKG/ECG	177,973.00	5,423.00	MRI SERVICES	321,889.00	102,636.00
IV THERAPY	237,767.00	40,043.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	747,732.00	311,292.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,542.00	0.00	REHAB THERAPY	0.00	3,150.00
RESPIRATORY SERVICES	71,466.00	15,303.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,110.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,152.00	34,961.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,001,979.00	131,078.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	295,852.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	167,005.30	276,950.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,381.29	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,952.00	12,156.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,109.35	85,012.20
LITHOTRIPSY	29,831.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	275,238.00	44,648.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,052.00	10,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	192,603.00	132,015.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	194,924.00	46,785.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	132,730.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,463.95	11,929.00			

TOTAL ANCILLARY	11,366,665.20	1,942,460.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,366,665.20	1,942,460.86

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	137,502.26	ADJUSTMENTS	0.00
COVERED CHARGES	93,309.80	CONTRACTUAL ALLOW	73,329.63
NON-COVERD CHARGES	44,192.46	TOTAL MEDICAID LIAB	19,980.17
		LESS: COB	19,947.17
		LESS: COPAYMENT	33.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,033.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,007.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,044.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,185.00	26,740.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,299.00	1,269.00
EKG/ECG	493.00	493.00	MRI SERVICES	9,850.00	0.00
IV THERAPY	484.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	6,368.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,700.00	778.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,762.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	644.66	461.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,975.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	119.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,604.00	2,934.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,822.00	1,788.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,149.00	3,361.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,114.40	0.00			

TOTAL ANCILLARY	93,309.80	44,192.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,309.80	44,192.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	221,375.95	ADJUSTMENTS	108.88
COVERED CHARGES	209,649.65	CONTRACTUAL ALLOW	204,838.81
NON-COVERD CHARGES	11,726.30	TOTAL MEDICAID LIAB	4,810.84
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	4,693.84
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,119.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,244.00	1,362.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,419.00	3,107.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,857.00	1,821.00
EKG/ECG	1,972.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,257.00	2,614.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	102,035.00	2,101.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,816.06	721.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,847.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	209,649.65	11,726.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	209,649.65	11,726.30

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,588.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,588.40	CONTRACTUAL ALLOW	1,158.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	429.60
		LESS: COB	429.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	1,578.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,588.40	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,588.40	0.00

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

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	77,302.20	ADJUSTMENTS	0.00
COVERED CHARGES	76,220.34	CONTRACTUAL ALLOW	65,339.14
NON-COVERD CHARGES	1,081.86	TOTAL MEDICAID LIAB	10,881.20
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	10,869.20
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	826.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,984.87	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	1,488.00	0.00
EKG/ECG	493.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	509.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,768.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,552.00	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	2,762.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,617.21	1,081.86
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,086.80	0.00			

TOTAL ANCILLARY	76,220.34	1,081.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	76,220.34	1,081.86

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,495,158.35	ADJUSTMENTS	3,003,063.70
COVERED CHARGES	90,314,154.75	CONTRACTUAL ALLOW	71,902,760.45
NON-COVERD CHARGES	3,181,003.60	TOTAL MEDICAID LIAB	18,411,394.30
		LESS: COB	169,941.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,241,453.19

TOTAL NUMBER OF ADMISSIONS 974

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,422	0	7,089,403.00	1,076,757.00
ROUTINE NURSERY	305	0	514,823.00	69,712.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	5.00
TOTAL ROUTINE	5,727	0	7,604,226.00	1,146,474.00
SPECIAL CARE SERVICES				
CCU	359	0	1,391,843.00	0.00
ICU	1,087	0	4,563,274.00	0.00
NICU	26	0	100,958.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,056,075.00	0.00
TOTAL ACCOMODATIONS	7,199	0	13,660,301.00	1,146,474.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,380,289.65	414,710.35	OTHER LAB	584,778.00	0.00
MED/SURG SUPPLY	4,384,101.07	697,192.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,829,363.00	136,685.00	EDUCATION & TRAINING	12,384.00	0.00
RADIOLOGY-DIAGNOSTIC	1,844,223.00	11,417.00	OTHER THERAPEUTIC SVC	0.00	1,860.00
CT SCAN	3,247,089.00	64,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	664,976.29	4,556.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	542,737.00	503.00	MRI SERVICES	747,943.00	6,816.00
IV THERAPY	1,740.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,963,658.50	24,535.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,179.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,265,772.00	10,557.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,466,601.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,106,129.00	3,066.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,920,906.00	7,239.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	814,619.00	7,768.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	315,545.00	619.00	INJECTABLE DRUGS	432.86	0.00
RADIOLOGY THERAPEUTIC	322,486.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	278,702.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	265,216.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,180,758.00	57,420.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,770.00	8,498.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,053,877.00	1,388.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	50,664.00
OTHER IMAGING SERVICE	680,698.00	12,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,447,706.00	477,827.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	136,638.00	28,149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,176,116.00	5,405.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,971.00	0.00			
ORGAN ACQUISITION	2,515,406.00	0.00			
TREATMENT/OBSERV. RM	370,042.04	0.00			

TOTAL ANCILLARY	76,653,853.75	2,034,529.60
TOTAL ACCOMODATIONS	13,660,301.00	1,146,474.00
TOTAL CHARGES	90,314,154.75	3,181,003.60

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 07/01/17 THROUGH 06/30/18
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	2017325052242	11/09/17 - 11/17/17	11/27/17	0.00	4,889.00	0.00	0.00	0.00
614	2018032055939	11/30/17 - 12/10/17	02/05/18	0.00	5,771.00	0.00	0.00	0.00
614	2018050009933	01/27/18 - 02/14/18	02/26/18	0.00	4,889.00	0.00	0.00	0.00
614	2018115039049	03/28/18 - 04/22/18	04/30/18	0.00	4,889.00	0.00	0.00	0.00
614	2018138051603	12/15/17 - 12/23/17	05/21/18	0.00	4,889.00	0.00	0.00	0.00
614	2318165000213	02/19/18 - 02/27/18	06/25/18	0.00	4,889.00	0.00	4,021.38	0.00
948	2218187012021	05/25/18 - 06/03/18	07/09/18	0.00	446.00	0.00	0.00	0.00
614	2018191047632	06/09/18 - 07/06/18	07/16/18	0.00	4,889.00	0.00	0.00	0.00
614	5218282000118	05/10/18 - 07/18/18	10/15/18	0.00	4,889.00	0.00	0.00	0.00
614	5218345000134	02/06/18 - 02/16/18	12/17/18	0.00	4,889.00	0.00	0.00	0.00
-1	2319044000048	05/25/18 - 06/02/18	02/25/19	0.00	446.00	0.00	1,904.76	0.00
614	2019135048118	12/22/17 - 01/06/18	05/20/19	0.00	4,889.00	0.00	0.00	0.00
TOTAL				0.00	50,664.00	0.00	5,926.14	0.00

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,870,292.71	ADJUSTMENTS	0.00
COVERED CHARGES	1,826,924.71	CONTRACTUAL ALLOW	1,075,650.05
NON-COVERD CHARGES	43,368.00	TOTAL MEDICAID LIAB	751,274.66
		LESS: COB	751,274.66
		LESS: COPAYMENT	0.00
		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	159	0	209,085.00	28,734.00
ROUTINE NURSERY	30	0	60,029.00	12,699.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	189	0	269,114.00	41,433.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	24	0	102,468.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	102,468.00	0.00
TOTAL ACCOMODATIONS	213	0	371,582.00	41,433.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329,134.81	0.00	OTHER LAB	17,187.00	0.00
MED/SURG SUPPLY	51,594.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	253,535.00	0.00	EDUCATION & TRAINING	172.00	0.00
RADIOLOGY-DIAGNOSTIC	30,755.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,331.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,761.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,048.00	0.00	MRI SERVICES	12,180.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,330.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,985.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,482.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,923.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,552.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,795.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,483.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	56,727.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	466.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,584.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,198.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,248.00	1,535.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,604.00	400.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,645.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,222.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,491.00	0.00			

TOTAL ANCILLARY	1,455,342.71	1,935.00
TOTAL ACCOMODATIONS	371,582.00	41,433.00
TOTAL CHARGES	1,826,924.71	43,368.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,148,597.39	ADJUSTMENTS	542,334.13
COVERED CHARGES	17,042,765.06	CONTRACTUAL ALLOW	14,820,183.77
NON-COVERD CHARGES	7,105,832.33	TOTAL MEDICAID LIAB	2,222,581.29
		LESS: COB	91,917.95
		LESS: COPAYMENT	5,589.23
		REIMBURSEMENT	2,125,074.11
		ALL OTHER	1,844,944.92
		FEE SCHEDULE-LAB	198,559.22
		INJECTABLE DRUGS	81,569.97

TOTAL NUMBER OF CLAIMS 3,903

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,333.99	923.92
MED/SURG SUPPLY	518,045.50	305,777.75
LABORATORY-GENERAL	0.00	164.00
RADIOLOGY-DIAGNOSTIC	597,183.00	95,684.00
CT SCAN	2,076,271.00	699,425.00
PHYSICAL THERAPY	2,698.00	9,168.06
EKG/ECG	273,313.00	5,533.00
IV THERAPY	21,744.00	0.00
OPERATING ROOM	1,266,268.00	541,865.00
LABOR/DELIVERY ROOM	12,849.00	0.00
RESPIRATORY SERVICES	162,970.00	75,387.00
ANESTHESIA	208,923.00	1,648.00
GI SERVICES	428,319.00	211,299.00
EMERGENCY ROOM	3,195,985.00	142,780.00
RECOVERY ROOM	283,566.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	394,063.00	843,019.00
OCCUPATIONAL THERAPY	0.00	3,354.00
SPEECH PATHOLOGY	1,414.00	5,026.00
RENAL DIALYSIS	0.00	68,904.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	235,279.00	117,065.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	364,763.00	135,726.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	221,964.00	72,086.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	174,865.00	274,402.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,038,183.00	643,116.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	306,353.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	282,206.02	9,811.00
OTHER LAB	242,508.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,032.00
OTHER THERAPEUTIC SVC	0.00	620.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,104,604.00	338,721.00
MRI SERVICES	636,019.00	168,413.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	653,921.48	1,771,511.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	105,154.07	510,952.63
NO CC/INVALID REV CODE	0.00	52,418.00

TOTAL ANCILLARY	17,042,765.06	7,105,832.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,042,765.06	7,105,832.33

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017282013066	10/06/17 - 10/06/17	10/16/17	0.00	4,490.00	0.00	0.00	0.00
614	2017282013066	10/06/17 - 10/06/17	10/16/17	0.00	399.00	0.00	0.00	0.00
614	2017282013068	10/05/17 - 10/05/17	10/16/17	0.00	5,372.00	0.00	0.00	0.00
614	2017282013068	10/05/17 - 10/05/17	10/16/17	0.00	399.00	0.00	0.00	0.00
614	2017289015232	10/11/17 - 10/11/17	10/23/17	0.00	4,490.00	0.00	0.00	0.00
614	2017289015232	10/11/17 - 10/11/17	10/23/17	0.00	399.00	0.00	0.00	0.00
614	2018078014846	03/14/18 - 03/14/18	03/26/18	0.00	5,372.00	0.00	0.00	0.00
614	2018078014846	03/14/18 - 03/14/18	03/26/18	0.00	399.00	0.00	0.00	0.00
614	5918107001347	04/09/18 - 04/09/18	04/23/18	0.00	8,980.00	0.00	0.00	0.00
614	5918107001347	04/09/18 - 04/09/18	04/23/18	0.00	798.00	0.00	0.00	0.00
614	2018137059215	05/14/18 - 05/14/18	05/21/18	0.00	4,490.00	0.00	0.00	0.00
614	2018137059215	05/14/18 - 05/14/18	05/21/18	0.00	399.00	0.00	0.00	0.00
614	2018138052880	05/14/18 - 05/14/18	05/21/18	0.00	5,372.00	0.00	0.00	0.00
614	2018138052880	05/14/18 - 05/14/18	05/21/18	0.00	399.00	0.00	0.00	0.00
614	5918169001259	06/11/18 - 06/11/18	06/25/18	0.00	4,490.00	0.00	0.00	0.00
614	5918169001259	06/11/18 - 06/11/18	06/25/18	0.00	399.00	0.00	0.00	0.00
614	2218192004274	06/14/18 - 06/14/18	07/16/18	0.00	5,372.00	0.00	0.00	0.00
614	2218192004274	06/14/18 - 06/14/18	07/16/18	0.00	399.00	0.00	0.00	0.00
TOTAL				0.00	52,418.00	0.00	0.00	0.00

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	489,980.85	ADJUSTMENTS	0.00
COVERED CHARGES	305,037.17	CONTRACTUAL ALLOW	187,804.05
NON-COVERD CHARGES	184,943.68	TOTAL MEDICAID LIAB	117,233.12
		LESS: COB	117,137.12
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,301.29	0.00	OTHER LAB	7,552.00	0.00
MED/SURG SUPPLY	17,759.78	8,316.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,595.00	598.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,180.00	14,775.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,533.00	7,850.00
EKG/ECG	4,024.00	0.00	MRI SERVICES	6,673.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,504.00	83,998.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,575.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,149.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,009.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,689.00	6,630.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,839.00	1,812.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,277.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,874.10	3,559.72
RADIOLOGY THERAPEUTIC	278.00	8,852.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,121.00	2,341.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	38,468.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,661.00	6,793.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,727.00	68.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,048.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,495.00	882.00			

TOTAL ANCILLARY	305,037.17	184,943.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	305,037.17	184,943.68

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	269,476.44	ADJUSTMENTS	52.94
COVERED CHARGES	230,591.53	CONTRACTUAL ALLOW	218,266.76
NON-COVERD CHARGES	38,884.91	TOTAL MEDICAID LIAB	12,324.77
		LESS: COB	6,055.94
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	5,995.83
		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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,715.84	0.00	OTHER LAB	1,487.00	0.00
MED/SURG SUPPLY	1,010.24	324.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,275.00	1,251.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,738.00	23,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,891.00	2,590.00
EKG/ECG	3,018.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,348.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	264.00	138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,779.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	147,082.00	1,929.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,872.75	1,790.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	184.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,926.00	7,782.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	230,591.53	38,884.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	230,591.53	38,884.91

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,527.20	ADJUSTMENTS	0.00
COVERED CHARGES	18,762.20	CONTRACTUAL ALLOW	12,468.02
NON-COVERD CHARGES	12,765.00	TOTAL MEDICAID LIAB	6,294.18
		LESS: COB	6,279.18
		LESS: COPAYMENT	15.00
		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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,196.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,417.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,747.00	160.00
EKG/ECG	1,006.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,787.00	306.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	390.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,357.00	882.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	18,762.20	12,765.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,762.20	12,765.00

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,969,824.13	ADJUSTMENTS	93,829.42
COVERED CHARGES	2,504,353.49	CONTRACTUAL ALLOW	2,255,271.10
NON-COVERD CHARGES	465,470.64	TOTAL MEDICAID LIAB	249,082.39
		LESS: COB	5,257.50
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	243,536.89

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,094.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	178,235.75	149,364.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	172.00
RADIOLOGY-DIAGNOSTIC	7,357.00	85,458.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,122.00	13,882.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,050.00	FEE SCHEDULE LAB	36,441.00	1,293.00
EKG/ECG	2,012.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,262.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	622,925.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90,083.00	264.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,029.00	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	34,719.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	409,626.85	41,877.58
RADIOLOGY THERAPEUTIC	264,098.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,201.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,828.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	684.00	233.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,231.72	109,894.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,772.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,496.00	2,334.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	363,292.00	54,619.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,872.40	0.00			

TOTAL ANCILLARY	2,504,353.49	465,470.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,504,353.49	465,470.64

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,364.25	ADJUSTMENTS	5,517.34
COVERED CHARGES	68,814.25	CONTRACTUAL ALLOW	54,929.44
NON-COVERD CHARGES	550.00	TOTAL MEDICAID LIAB	13,884.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,884.81

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8	0	4,400.00	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	8	0	4,400.00	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	8	0	4,400.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,272.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,610.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,943.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,144.00	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	1,685.00	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	11,245.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,110.00	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	11,446.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,959.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	550.00			

TOTAL ANCILLARY	64,414.25	550.00
TOTAL ACCOMODATIONS	4,400.00	0.00
TOTAL CHARGES	68,814.25	550.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,847,607.21	ADJUSTMENTS	173,590.03
COVERED CHARGES	6,639,077.46	CONTRACTUAL ALLOW	5,603,277.27
NON-COVERD CHARGES	208,529.75	TOTAL MEDICAID LIAB	1,035,800.19
		LESS: COB	0.00
		LESS: COPAYMENT	978.00
		REIMBURSEMENT	1,034,822.19
		ALL OTHER	934,780.32
		FEE SCHEDULE-LAB	84,338.54
		INJECTABLE DRUGS	15,703.33

TOTAL NUMBER OF CLAIMS 2,313

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,130.75	0.00	OTHER LAB	8,915.00	0.00
MED/SURG SUPPLY	247,198.96	2,642.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	368.00	0.00
RADIOLOGY-DIAGNOSTIC	370,174.00	6,085.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	569,522.00	12,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,234,773.00	45,417.00
EKG/ECG	117,613.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	35,548.00	1,600.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,933.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,547.00	25,227.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,462,444.00	75,508.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	297,529.75	12,091.75
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	13,835.00	4,570.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,260.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,253.00	610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	489.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,979.00	12,295.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,635.00	10,220.00			

TOTAL ANCILLARY	6,639,077.46	208,529.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,639,077.46	208,529.75

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,306.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,134.00	CONTRACTUAL ALLOW	19,919.40
NON-COVERD CHARGES	5,172.00	TOTAL MEDICAID LIAB	17,214.60
		LESS: COB	17,214.16
		LESS: COPAYMENT	0.44
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,689.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,020.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,771.00	152.00
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	24,653.00	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	2,097.50	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	152.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	37,134.00	5,172.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,134.00	5,172.00

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

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	342,751.00	ADJUSTMENTS	1,120.00
COVERED CHARGES	340,525.00	CONTRACTUAL ALLOW	331,725.00
NON-COVERD CHARGES	2,226.00	TOTAL MEDICAID LIAB	8,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	8,527.00
		TOTAL NUMBER OF CLAIMS	176

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	706.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,967.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,729.00	795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,264.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,623.00	879.00
EKG/ECG	2,022.00	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	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	262,622.00	380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,607.75	172.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	73.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	340,525.00	2,226.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	340,525.00	2,226.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,420.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,293.00	CONTRACTUAL ALLOW	3,203.96
NON-COVERD CHARGES	127.00	TOTAL MEDICAID LIAB	2,089.04
		LESS: COB	2,083.04
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	126.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.00	127.00
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	4,734.00	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	166.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,293.00	127.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,293.00	127.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	169,079.50	ADJUSTMENTS	19,391.56
COVERED CHARGES	162,724.50	CONTRACTUAL ALLOW	138,410.05
NON-COVERD CHARGES	6,355.00	TOTAL MEDICAID LIAB	24,314.45
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	24,218.45

TOTAL NUMBER OF CLAIMS 5

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,162.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,795.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,389.00	922.00
EKG/ECG	674.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,940.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,636.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	862.00	4,738.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,790.00	650.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	978.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,008.25	45.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	24,069.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,390.00	0.00			

TOTAL ANCILLARY	162,724.50	6,355.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	162,724.50	6,355.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,712.50	ADJUSTMENTS	22,923.76
COVERED CHARGES	163,391.67	CONTRACTUAL ALLOW	73,333.44
NON-COVERD CHARGES	7,320.83	TOTAL MEDICAID LIAB	90,058.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,058.23

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	46	0	16,100.00	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	46	0	16,100.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	18	0	12,150.00	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	18	0	12,150.00	0.00
TOTAL ACCOMODATIONS	64	0	28,250.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,992.00	0.00	OTHER LAB	1,954.96	0.00
MED/SURG SUPPLY	12,903.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,529.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,091.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,511.62	7,117.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,606.89	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	13,814.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,436.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,176.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	337.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	754.14	203.53			
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	1,382.18	0.00			

TOTAL ANCILLARY	135,141.67	7,320.83
TOTAL ACCOMODATIONS	28,250.00	0.00
TOTAL CHARGES	163,391.67	7,320.83

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	783,612.98	ADJUSTMENTS	36,625.55
COVERED CHARGES	683,445.00	CONTRACTUAL ALLOW	382,491.00
NON-COVERD CHARGES	100,167.98	TOTAL MEDICAID LIAB	300,954.00
		LESS: COB	220.52
		LESS: COPAYMENT	456.00
		REIMBURSEMENT	300,277.48
		ALL OTHER	274,269.53
		FEE SCHEDULE-LAB	21,669.48
		INJECTABLE DRUGS	4,338.47

TOTAL NUMBER OF CLAIMS 620

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,915.40	1,613.20	OTHER LAB	28,535.79	0.00
MED/SURG SUPPLY	25,959.95	789.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,480.78	5,384.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	125,375.38	52,544.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	639.00	273.00	FEE SCHEDULE LAB	111,210.85	8,750.21
EKG/ECG	9,728.25	0.00	MRI SERVICES	5,189.20	2,227.17
IV THERAPY	6,461.30	2,671.14	PROFESSIONAL FEES	0.00	990.00
OPERATING ROOM	8,711.86	2,595.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,049.19	1,212.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,249.60	896.84	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	173,340.10	4,372.46	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,300.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,372.70	4,910.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	165.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69.63	564.55	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,279.28	2,518.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,147.77	1,628.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,070.00	5,560.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,828.67	314.85			

TOTAL ANCILLARY	683,445.00	99,817.98
TOTAL ACCOMODATIONS	0.00	350.00
TOTAL CHARGES	683,445.00	100,167.98

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,529.52	ADJUSTMENTS	0.00
COVERED CHARGES	280.00	CONTRACTUAL ALLOW	48.11
NON-COVERD CHARGES	2,249.52	TOTAL MEDICAID LIAB	231.89
		LESS: COB	228.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	2,249.52	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	280.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	280.00	2,249.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	280.00	2,249.52

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,373.71	ADJUSTMENTS	1,068.02
COVERED CHARGES	47,393.62	CONTRACTUAL ALLOW	43,736.73
NON-COVERD CHARGES	980.09	TOTAL MEDICAID LIAB	3,656.89
		LESS: COB	23.92
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	3,482.97
		TOTAL NUMBER OF CLAIMS	74

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	964.00	0.00	OTHER LAB	332.08	0.00
MED/SURG SUPPLY	931.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,586.66	525.97	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,412.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,209.29	354.12
EKG/ECG	796.51	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	25,488.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,362.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	310.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,393.62	980.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,393.62	980.09

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,751.51	ADJUSTMENTS	0.00
COVERED CHARGES	14,176.51	CONTRACTUAL ALLOW	9,313.62
NON-COVERD CHARGES	575.00	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,288.27	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	30.08	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	1,966.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,921.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	645.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	390.00	575.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,176.51	575.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,176.51	575.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,502,927.01	ADJUSTMENTS	28,485.30
COVERED CHARGES	1,472,967.26	CONTRACTUAL ALLOW	650,667.38
NON-COVERD CHARGES	29,959.75	TOTAL MEDICAID LIAB	822,299.88
		LESS: COB	12,567.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	809,732.02

TOTAL NUMBER OF ADMISSIONS 140

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	255	0	132,600.00	18,400.00
ROUTINE NURSERY	42	0	21,840.00	5,774.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	297	0	154,440.00	24,174.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	123	0	162,979.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	162,979.00	0.00
TOTAL ACCOMODATIONS	420	0	317,419.00	24,174.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,501.00	0.00	OTHER LAB	8,568.00	0.00
MED/SURG SUPPLY	71,040.73	394.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	184,602.36	0.00	EDUCATION & TRAINING	2.00	0.00
RADIOLOGY-DIAGNOSTIC	23,803.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,805.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,171.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,977.00	0.00	MRI SERVICES	25,839.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,323.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,520.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,050.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,593.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,771.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,908.00	0.00	INJECTABLE DRUGS	115,325.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	868.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	18,726.00	2,340.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	137.50	151.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,207.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,540.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,569.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,671.00	2,899.50			
AUDIOLOGY	5,265.00	0.00			
CARDIOLOGY	29,289.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,412.00	0.00			

TOTAL ANCILLARY	1,155,548.26	5,785.75
TOTAL ACCOMODATIONS	317,419.00	24,174.00
TOTAL CHARGES	1,472,967.26	29,959.75

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,745,246.83	ADJUSTMENTS	95,789.41
COVERED CHARGES	1,706,740.28	CONTRACTUAL ALLOW	1,333,427.14
NON-COVERD CHARGES	38,506.55	TOTAL MEDICAID LIAB	373,313.14
		LESS: COB	678.96
		LESS: COPAYMENT	1,284.00
		REIMBURSEMENT	371,350.18
		ALL OTHER	311,080.12
		FEE SCHEDULE-LAB	56,049.57
		INJECTABLE DRUGS	4,220.49

TOTAL NUMBER OF CLAIMS 1,698

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,933.31	1,130.00	OTHER LAB	29,414.50	0.00
MED/SURG SUPPLY	45,468.75	300.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,591.50	1,080.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	191,637.50	1,152.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,026.75	719.50	FEE SCHEDULE LAB	336,563.90	6,850.00
EKG/ECG	23,202.00	639.00	MRI SERVICES	93,877.50	1,785.00
IV THERAPY	7,693.00	440.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	156,408.64	9,344.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,332.00	212.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,131.00	311.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,591.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	47,893.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	318,159.71	1,572.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,339.00	5,583.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	140.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,340.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,660.50	605.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	854.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,701.50	1,219.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,782.00	572.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,205.50	0.00			
AUDIOLOGY	0.00	292.50			
CARDIOLOGY	24,094.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,028.62	2,357.00			

TOTAL ANCILLARY	1,706,740.28	38,506.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,706,740.28	38,506.55

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,868.20	ADJUSTMENTS	0.00
COVERED CHARGES	26,739.70	CONTRACTUAL ALLOW	13,963.54
NON-COVERD CHARGES	2,128.50	TOTAL MEDICAID LIAB	12,776.16
		LESS: COB	12,755.16
		LESS: COPAYMENT	21.00
		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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,732.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	586.50	109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,594.00	216.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,608.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,012.00	0.00	FEE SCHEDULE LAB	3,971.20	204.00
EKG/ECG	396.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	859.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	636.00	258.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.50	58.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,824.50	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	390.00	944.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,716.50	339.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,365.50	0.00			

TOTAL ANCILLARY	26,739.70	2,128.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,739.70	2,128.50

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,812.50	ADJUSTMENTS	320.64
COVERED CHARGES	74,989.00	CONTRACTUAL ALLOW	69,378.17
NON-COVERD CHARGES	823.50	TOTAL MEDICAID LIAB	5,610.83
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	5,391.83
		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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,556.00	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	644.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,119.00	286.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,691.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,736.50	125.00
EKG/ECG	938.00	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	291.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,816.00	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	1,791.00	400.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	406.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,989.00	823.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,989.00	823.50

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,922.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,865.50	CONTRACTUAL ALLOW	894.38
NON-COVERD CHARGES	57.00	TOTAL MEDICAID LIAB	971.12
		LESS: COB	962.12
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.00	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	152.00	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	24.00	17.00
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	1,564.50	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	40.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,865.50	57.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,865.50	57.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	362,256.95	ADJUSTMENTS	0.00
COVERED CHARGES	330,936.27	CONTRACTUAL ALLOW	215,115.98
NON-COVERD CHARGES	31,320.68	TOTAL MEDICAID LIAB	115,820.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	115,820.29

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	65	0	43,375.00	21,094.00
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	65	0	43,375.00	21,094.00
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	65	0	43,375.00	21,094.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,798.54	0.00	OTHER LAB	2,570.88	0.00
MED/SURG SUPPLY	23,911.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,954.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,958.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,220.80	1,330.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	465.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,715.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,641.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,600.00	5,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,197.76	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	14,656.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,406.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	470.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,047.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	954.72	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,016.44	3,696.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,116.80	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	13,776.68	0.00			

TOTAL ANCILLARY	287,561.27	10,226.68
TOTAL ACCOMODATIONS	43,375.00	21,094.00
TOTAL CHARGES	330,936.27	31,320.68

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	857,001.84	ADJUSTMENTS	64,468.76
COVERED CHARGES	629,724.71	CONTRACTUAL ALLOW	435,950.28
NON-COVERD CHARGES	227,277.13	TOTAL MEDICAID LIAB	193,774.43
		LESS: COB	192.52
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	193,035.91
		ALL OTHER	174,287.62
		FEE SCHEDULE-LAB	17,577.73
		INJECTABLE DRUGS	1,170.56

TOTAL NUMBER OF CLAIMS 527

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,234.83	4,352.81	OTHER LAB	7,675.64	0.00
MED/SURG SUPPLY	40,977.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,660.56	6,947.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,582.48	108,289.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	825.36	FEE SCHEDULE LAB	161,321.80	13,629.96
EKG/ECG	9,612.64	1,962.24	MRI SERVICES	2,571.92	0.00
IV THERAPY	65,539.24	9,272.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,235.52	19,980.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,237.44	3,713.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,454.00	15,847.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,240.14	35,389.62
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,686.76	1,954.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,118.96	591.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,739.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,375.32	781.22			

TOTAL ANCILLARY	629,724.71	227,277.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	629,724.71	227,277.13

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,396.81	ADJUSTMENTS	0.00
COVERED CHARGES	628.16	CONTRACTUAL ALLOW	46.72
NON-COVERD CHARGES	3,768.65	TOTAL MEDICAID LIAB	581.44
		LESS: COB	576.35
		LESS: COPAYMENT	5.09
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	20.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,217.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,530.32	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	589.12	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	628.16	3,768.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	628.16	3,768.65

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,203.95	ADJUSTMENTS	1,312.00
COVERED CHARGES	31,961.15	CONTRACTUAL ALLOW	29,781.15
NON-COVERD CHARGES	7,242.80	TOTAL MEDICAID LIAB	2,180.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	2,108.00
		TOTAL NUMBER OF CLAIMS	34

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	633.88	179.06	OTHER LAB	608.40	0.00
MED/SURG SUPPLY	1,039.19	6.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	638.00	373.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,086.80	4,963.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,364.88	1,076.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,800.39	146.26	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,077.84	149.76	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,711.77	348.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,961.15	7,242.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,961.15	7,242.80

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,861.06	ADJUSTMENTS	4,669.86
COVERED CHARGES	28,168.72	CONTRACTUAL ALLOW	18,817.00
NON-COVERD CHARGES	5,692.34	TOTAL MEDICAID LIAB	9,351.72
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,345.72
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	712.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	378.63	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	3,481.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,304.16	328.64
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,728.60	610.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	644.80	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	1,320.12	1,271.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,080.00	0.00			

TOTAL ANCILLARY	28,168.72	5,692.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,168.72	5,692.34

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	54,583,505.37	ADJUSTMENTS	611,240.89
COVERED CHARGES	53,730,597.56	CONTRACTUAL ALLOW	44,863,460.33
NON-COVERD CHARGES	852,907.81	TOTAL MEDICAID LIAB	8,867,137.23
		LESS: COB	52,691.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,814,445.46

TOTAL NUMBER OF ADMISSIONS 662

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,219	0	2,403,362.84	602,703.16
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	3,219	0	2,403,362.84	602,703.16
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	726	0	1,933,559.19	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	726	0	1,933,559.19	0.00
TOTAL ACCOMODATIONS	3,945	0	4,336,922.03	602,703.16

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,360,119.15	0.00	OTHER LAB	380,632.60	0.00
MED/SURG SUPPLY	3,074,753.11	1,250.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,063,142.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,185,866.48	988.20	OTHER THERAPEUTIC SVC	0.00	18,863.10
CT SCAN	3,294,953.88	42,812.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	774,029.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	521,742.08	0.00	MRI SERVICES	595,219.00	0.00
IV THERAPY	135,620.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,508,711.30	48,868.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,875,310.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	895,628.90	0.00	AMBULANCE	0.00	3,889.15
GI SERVICES	92,408.80	3,444.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,743,640.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	421,813.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	30,944.10
LABORATORY PATHOLOGIC	298,112.32	0.00	INJECTABLE DRUGS	3,659,137.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	428,070.41	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	100,180.48	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	229,714.68	14,693.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,789.75	442.00	TRAUMA RESPONSE	0.00	20,790.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,234,482.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	484,010.10	25,980.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	408,975.60	37,238.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	392,357.68	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,086,865.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,101.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	111,285.66	0.00			

TOTAL ANCILLARY	49,393,675.53	250,204.65
TOTAL ACCOMODATIONS	4,336,922.03	602,703.16
TOTAL CHARGES	53,730,597.56	852,907.81

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017335089442	10/12/17 - 11/07/17	12/11/17	0.00	0.00	0.00	0.00	0.00
24	2019122093837	06/26/18 - 07/20/18	05/06/19	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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,576,779.09	ADJUSTMENTS	171,841.33
COVERED CHARGES	22,352,494.08	CONTRACTUAL ALLOW	20,565,290.11
NON-COVERD CHARGES	3,224,285.01	TOTAL MEDICAID LIAB	1,787,203.97
		LESS: COB	0.00
		LESS: COPAYMENT	4,873.97
		REIMBURSEMENT	1,782,330.00
		ALL OTHER	1,630,986.34
		FEE SCHEDULE-LAB	142,830.78
		INJECTABLE DRUGS	8,512.88

TOTAL NUMBER OF CLAIMS 3,509

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,926.00	221,685.10	OTHER LAB	130,386.30	0.00
MED/SURG SUPPLY	564,580.50	76,895.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,175,374.96	214,768.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,559,859.20	589,449.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,305.30	156,922.80	FEE SCHEDULE LAB	5,791,804.88	309,590.53
EKG/ECG	486,571.52	613.44	MRI SERVICES	171,688.10	67,041.80
IV THERAPY	923,402.71	105,766.14	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,058,486.30	315,071.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	287.10
RESPIRATORY SERVICES	56,070.50	387.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	379,974.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	101,609.10	35,729.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,585,427.24	21,743.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	229,534.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181,984.24	166,705.59
RADIOLOGY THERAPEUTIC	25,400.00	2,094.40	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	55,154.70	33,502.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	9,036.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,223.88	3,629.11	TRAUMA RESPONSE	0.00	115,830.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	198,916.00	29,350.00
LITHOTRIPSY	182,985.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	128,659.30	41,438.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,106.00	8,561.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	627,399.44	247,118.88			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	885,151.50	400,661.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,167.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	311,344.23	50,404.77			

TOTAL ANCILLARY	22,352,494.08	3,224,285.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,352,494.08	3,224,285.01

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	341,093.29	ADJUSTMENTS	0.00
COVERED CHARGES	223,546.13	CONTRACTUAL ALLOW	139,268.25
NON-COVERD CHARGES	117,547.16	TOTAL MEDICAID LIAB	84,277.88
		LESS: COB	84,247.88
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,194.21	950.92	OTHER LAB	3,823.90	0.00
MED/SURG SUPPLY	5,052.00	243.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,663.24	1,654.56	OTHER THERAPEUTIC SVC	0.00	4,265.80
CT SCAN	17,328.60	23,026.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	517.00	FEE SCHEDULE LAB	52,965.07	5,846.44
EKG/ECG	5,475.52	613.44	MRI SERVICES	0.00	6,200.00
IV THERAPY	3,773.24	609.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,539.30	16,588.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	990.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,710.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,079.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,076.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	579.09	846.73
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	100.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,550.00	0.00
LITHOTRIPSY	0.00	40,256.70	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,797.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,703.72			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,751.80	6,100.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,644.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,110.24	1,024.00			

TOTAL ANCILLARY	223,546.13	117,547.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	223,546.13	117,547.16

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	902,659.23	ADJUSTMENTS	161.82
COVERED CHARGES	847,880.54	CONTRACTUAL ALLOW	834,678.70
NON-COVERD CHARGES	54,778.69	TOTAL MEDICAID LIAB	13,201.84
		LESS: COB	0.00
		LESS: COPAYMENT	549.00
		REIMBURSEMENT	12,652.84
		TOTAL NUMBER OF CLAIMS	236

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,875.26	6,649.41	OTHER LAB	7,513.80	0.00
MED/SURG SUPPLY	1,400.00	432.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,241.60	12,147.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	197,332.64	21,080.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	237,806.03	7,211.24
EKG/ECG	11,246.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,423.42	505.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,426.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,485.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	293,196.28	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	2,879.31	4,832.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,054.80	1,920.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	847,880.54	54,778.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	847,880.54	54,778.69

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,665.70	ADJUSTMENTS	0.00
COVERED CHARGES	16,009.35	CONTRACTUAL ALLOW	10,371.36
NON-COVERD CHARGES	8,656.35	TOTAL MEDICAID LIAB	5,637.99
		LESS: COB	5,628.99
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	752.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,862.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,195.84	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	428.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,286.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.04	41.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,009.35	8,656.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,009.35	8,656.35

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,254,223.22	ADJUSTMENTS	5,332.98
COVERED CHARGES	4,084,895.62	CONTRACTUAL ALLOW	3,911,346.30
NON-COVERD CHARGES	169,327.60	TOTAL MEDICAID LIAB	173,549.32
		LESS: COB	0.00
		LESS: COPAYMENT	238.90
		REIMBURSEMENT	173,310.42

TOTAL NUMBER OF CLAIMS 33

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,319.86	5,038.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79,613.00	5,074.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,449.40	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	36,544.41	0.00
EKG/ECG	10,292.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,658.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,563,105.50	68,036.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	247.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,251.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,400.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	593,512.90	46,808.28
RADIOLOGY THERAPEUTIC	38,894.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	75.60
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,515,181.00	3,700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	146,111.40	40,595.50			
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	904.32	0.00			

TOTAL ANCILLARY	4,084,895.62	169,327.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,084,895.62	169,327.60

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,581,155.56	ADJUSTMENTS	168,757.16
COVERED CHARGES	15,929,884.84	CONTRACTUAL ALLOW	11,841,822.77
NON-COVERD CHARGES	651,270.72	TOTAL MEDICAID LIAB	4,088,062.07
		LESS: COB	89,445.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,998,616.93

TOTAL NUMBER OF ADMISSIONS 499

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,782	0	1,237,100.00	356,134.00
ROUTINE NURSERY	462	0	1,331,906.00	78,157.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,244	0	2,569,006.00	434,291.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	243	0	438,884.00	0.00
NICU	73	0	493,245.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	316	0	932,129.00	0.00
TOTAL ACCOMODATIONS	2,560	0	3,501,135.00	434,291.00

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	890,957.87	0.00	OTHER LAB	105,433.00	0.00
MED/SURG SUPPLY	556,966.81	188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,626,597.87	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,053,048.00	3,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	84,355.51	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	194,492.00	0.00	MRI SERVICES	189,083.00	0.00
IV THERAPY	229,458.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	596,736.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	379,704.00	11,951.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	594,135.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	208,360.00	1,278.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	636,191.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	143,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	24,808.72
LABORATORY PATHOLOGIC	128,058.00	0.00	INJECTABLE DRUGS	916,309.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,209.15	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	35,862.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	174,265.00	11,508.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,249.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	159,310.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	50,554.00
OTHER IMAGING SERVICE	160,875.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	224,261.00	100,338.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,868.00	13,000.00			
AUDIOLOGY	14,393.00	0.00			
CARDIOLOGY	440,697.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,913.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	97,912.00	0.00			

TOTAL ANCILLARY	12,428,749.84	216,979.72
TOTAL ACCOMODATIONS	3,501,135.00	434,291.00
TOTAL CHARGES	15,929,884.84	651,270.72

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 10/01/17 THROUGH 06/30/18
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	2018051112046	10/24/17 - 10/27/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018051113088	10/15/17 - 10/19/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018051113100	10/20/17 - 10/21/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018052000349	02/13/18 - 02/14/18	02/26/18	0.00	2,895.00	0.00	0.00	0.00
615	2018051112533	02/07/18 - 02/11/18	02/26/18	0.00	5,726.00	0.00	0.00	0.00
615	2018096075836	01/15/18 - 01/17/18	04/16/18	0.00	2,783.00	0.00	0.00	0.00
615	2018106030500	04/07/18 - 04/10/18	04/23/18	0.00	5,726.00	0.00	0.00	0.00
615	2018128074181	04/30/18 - 05/03/18	05/14/18	0.00	5,726.00	0.00	0.00	0.00
615	2018136072486	01/21/18 - 01/23/18	05/21/18	0.00	5,505.00	0.00	0.00	0.00
615	2018190025030	06/22/18 - 06/28/18	07/16/18	0.00	2,895.00	0.00	0.00	0.00
615	2318205000410	10/17/17 - 10/19/17	08/20/18	0.00	2,783.00	0.00	717.36	0.00
TOTAL				0.00	50,554.00	0.00	717.36	0.00

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

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,118,620.86	ADJUSTMENTS	185,542.11
COVERED CHARGES	8,967,219.67	CONTRACTUAL ALLOW	7,987,593.57
NON-COVERD CHARGES	1,151,401.19	TOTAL MEDICAID LIAB	979,626.10
		LESS: COB	2,564.40
		LESS: COPAYMENT	2,017.75
		REIMBURSEMENT	975,043.95
		ALL OTHER	855,781.71
		FEE SCHEDULE-LAB	110,750.36
		INJECTABLE DRUGS	8,511.88

TOTAL NUMBER OF CLAIMS 2,662

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,168.72	2,720.09	OTHER LAB	81,344.00	0.00
MED/SURG SUPPLY	170,002.41	19,305.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	247,472.00	69,907.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,485,547.00	268,009.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,218.00	6,779.00	FEE SCHEDULE LAB	2,353,096.79	203,107.80
EKG/ECG	237,828.00	764.00	MRI SERVICES	180,640.00	24,140.00
IV THERAPY	382,801.00	38,175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	287,330.72	107,065.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,035.00	12,421.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	226,349.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	179,766.61	79,170.39	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,961,888.00	21,042.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,440.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,894.92	9,727.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,817.00	832.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,346.00	3,556.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,407.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,928.00	12,497.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,986.50	12,754.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,414.00
OTHER IMAGING SERVICE	352,253.00	84,688.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,805.00	12,890.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,214.00	75,980.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	117,095.00	45,291.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	223,953.00	759.00			

TOTAL ANCILLARY	8,967,219.67	1,151,401.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,967,219.67	1,151,401.19

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 10/01/17 THROUGH 06/30/18
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	2018051113693	01/24/18 - 01/24/18	02/26/18	0.00	2,783.00	0.00	0.00	0.00
615	2018066002572	02/10/18 - 02/10/18	03/12/18	0.00	2,895.00	0.00	0.00	0.00
615	5918095000048	10/31/17 - 10/31/17	04/09/18	0.00	2,783.00	0.00	0.00	0.00
615	5918095000048	10/31/17 - 10/31/17	04/09/18	0.00	2,722.00	0.00	0.00	0.00
615	5918128001838	12/04/17 - 12/04/17	05/14/18	0.00	2,783.00	0.00	0.00	0.00
615	5918128001838	12/04/17 - 12/04/17	05/14/18	0.00	2,722.00	0.00	0.00	0.00
615	5918310003004	06/12/18 - 06/12/18	11/12/18	0.00	2,895.00	0.00	0.00	0.00
615	5918310003004	06/12/18 - 06/12/18	11/12/18	0.00	2,831.00	0.00	0.00	0.00
TOTAL				0.00	22,414.00	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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	158,900.17	ADJUSTMENTS	0.00
COVERED CHARGES	125,353.61	CONTRACTUAL ALLOW	91,486.30
NON-COVERD CHARGES	33,546.56	TOTAL MEDICAID LIAB	33,867.31
		LESS: COB	33,849.31
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,268.85	265.14	OTHER LAB	2,728.00	0.00
MED/SURG SUPPLY	786.00	262.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,617.00	1,730.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,469.00	18,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,771.00	254.00	FEE SCHEDULE LAB	41,342.00	1,771.00
EKG/ECG	2,786.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,064.00	1,087.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,417.00	3,264.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	205.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,291.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,332.50	2,332.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,025.00	401.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,871.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,172.26	334.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	452.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	843.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,756.00	2,710.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	125,353.61	33,546.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	125,353.61	33,546.56

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338,919.58	ADJUSTMENTS	432.52
COVERED CHARGES	315,635.58	CONTRACTUAL ALLOW	303,384.72
NON-COVERD CHARGES	23,284.00	TOTAL MEDICAID LIAB	12,250.86
		LESS: COB	0.00
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	11,878.86
		TOTAL NUMBER OF CLAIMS	219

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

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	4,409.00	0.00
MED/SURG SUPPLY	30.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,368.00	5,318.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,014.00	7,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,843.00	FEE SCHEDULE LAB	102,570.40	4,463.00
EKG/ECG	6,654.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,872.00	1,417.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,208.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,886.00	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	1,489.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,431.00	1,586.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,704.00	0.00			

TOTAL ANCILLARY	315,635.58	23,284.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	315,635.58	23,284.00

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

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,965.19	ADJUSTMENTS	0.00
COVERED CHARGES	14,086.19	CONTRACTUAL ALLOW	4,241.64
NON-COVERD CHARGES	6,879.00	TOTAL MEDICAID LIAB	9,844.55
		LESS: COB	9,838.55
		LESS: COPAYMENT	6.00
		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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	436.00	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	6,692.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,396.00	187.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	387.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,160.00	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	707.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,086.19	6,879.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,086.19	6,879.00

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

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,351.35	ADJUSTMENTS	11,087.46
COVERED CHARGES	137,585.68	CONTRACTUAL ALLOW	120,949.99
NON-COVERD CHARGES	45,765.67	TOTAL MEDICAID LIAB	16,635.69
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	16,623.69

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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	345.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,902.25	6,803.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,710.00	2,687.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,095.00	0.00
EKG/ECG	796.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	312.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,413.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	214.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,051.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,855.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,710.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,656.43	1,370.75
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	24,372.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,559.00	34,559.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,704.00	0.00			

TOTAL ANCILLARY	137,585.68	45,765.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,585.68	45,765.67

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

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	245,817.86	ADJUSTMENTS	10,887.54
COVERED CHARGES	168,395.86	CONTRACTUAL ALLOW	103,091.62
NON-COVERD CHARGES	77,422.00	TOTAL MEDICAID LIAB	65,304.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	65,304.24

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	40	0	42,578.00	77,422.00
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	40	0	42,578.00	77,422.00
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	40	0	42,578.00	77,422.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,747.60	0.00	OTHER LAB	533.55	0.00
MED/SURG SUPPLY	909.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,358.92	0.00	EDUCATION & TRAINING	143.16	0.00
RADIOLOGY-DIAGNOSTIC	2,058.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,590.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	447.78	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,586.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,172.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,438.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,202.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,681.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,223.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	505.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,218.08	0.00			

TOTAL ANCILLARY	125,817.86	0.00
TOTAL ACCOMODATIONS	42,578.00	77,422.00
TOTAL CHARGES	168,395.86	77,422.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,716,771.61	ADJUSTMENTS	73,223.57
COVERED CHARGES	1,597,908.22	CONTRACTUAL ALLOW	1,173,471.42
NON-COVERD CHARGES	118,863.39	TOTAL MEDICAID LIAB	424,436.80
		LESS: COB	3,333.41
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	420,497.39
		ALL OTHER	262,049.07
		FEE SCHEDULE-LAB	158,288.22
		INJECTABLE DRUGS	160.10

TOTAL NUMBER OF CLAIMS 1,792

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,921.68	83.00	OTHER LAB	6,705.20	0.00
MED/SURG SUPPLY	3,222.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	190.88
RADIOLOGY-DIAGNOSTIC	46,119.77	1,111.57	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,033.40	12,817.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,816.04	18,164.53	FEE SCHEDULE LAB	894,771.19	13,152.68
EKG/ECG	23,014.85	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	40,400.45	7,738.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	168,722.36	49,934.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,493.39	1,198.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	196,693.42	6,100.61	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	459.75	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	2,132.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,270.25	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	288.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,131.92	4,910.35			

TOTAL ANCILLARY	1,597,908.22	115,863.39
TOTAL ACCOMODATIONS	0.00	3,000.00
TOTAL CHARGES	1,597,908.22	118,863.39

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	657.52	ADJUSTMENTS	0.00
COVERED CHARGES	645.52	CONTRACTUAL ALLOW	303.61
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	341.91
		LESS: COB	341.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	149.70	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	274.72	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	221.10	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	645.52	12.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	645.52	12.00

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

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,857.96	ADJUSTMENTS	1,918.00
COVERED CHARGES	35,674.40	CONTRACTUAL ALLOW	31,294.40
NON-COVERD CHARGES	183.56	TOTAL MEDICAID LIAB	4,380.00
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	4,281.00
		TOTAL NUMBER OF CLAIMS	72

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,707.38	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	1,773.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,074.15	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,224.24	183.56
EKG/ECG	689.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,563.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.57	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,238.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,674.40	183.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,674.40	183.56

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,763.45	ADJUSTMENTS	4,856.89
COVERED CHARGES	112,476.48	CONTRACTUAL ALLOW	93,024.92
NON-COVERD CHARGES	3,286.97	TOTAL MEDICAID LIAB	19,451.56
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	19,436.56

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,386.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	353.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
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	576.28	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	101,109.30	2,990.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	517.73	236.50	FREE STANDING CLINIC	0.00	0.00
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	6,533.24	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,476.48	3,286.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	112,476.48	3,286.97

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,370,170.42	ADJUSTMENTS	1,016,455.43
COVERED CHARGES	50,601,075.23	CONTRACTUAL ALLOW	43,673,717.19
NON-COVERD CHARGES	1,769,095.19	TOTAL MEDICAID LIAB	6,927,358.04
		LESS: COB	81,400.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,845,958.00

TOTAL NUMBER OF ADMISSIONS 684

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,140	0	3,559,559.00	436,054.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,140	0	3,559,559.00	436,054.80
SPECIAL CARE SERVICES				
CCU	643	0	1,732,574.00	0.00
ICU	2,662	0	8,580,930.60	375,706.40
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,305	0	10,313,504.60	375,706.40
TOTAL ACCOMODATIONS	5,445	0	13,873,063.60	811,761.20

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,763,584.73	248,433.15	OTHER LAB	155,925.63	0.00
MED/SURG SUPPLY	2,144,672.94	27,343.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,497,827.27	114,448.69	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	700,064.84	11,234.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,033,599.93	79,252.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	213,599.06	338.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	312,632.53	1,536.00	MRI SERVICES	628,645.15	0.00
IV THERAPY	191,716.00	1,786.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,431,248.48	3,437.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,859,093.34	284,754.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	463,023.02	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,551.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,090,364.90	9,127.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,846.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,754.00
LABORATORY PATHOLOGIC	124,832.09	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,459.12	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	93,922.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	774,057.96	1,384.92	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,633.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	206,966.91	0.00	IMPL DEV CHARGE PATIENTS	302,761.98	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	230,911.49	1,469.83			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	217,239.74	165,178.66			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	757,040.32	735.30			
AUDIOLOGY	524.88	0.00			
CARDIOLOGY	1,144,169.21	1,910.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,353.90	209.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,741.94	0.00			

TOTAL ANCILLARY	36,728,011.63	957,333.99
TOTAL ACCOMODATIONS	13,873,063.60	811,761.20
TOTAL CHARGES	50,601,075.23	1,769,095.19

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,757,276.33	ADJUSTMENTS	268,741.62
COVERED CHARGES	23,572,145.64	CONTRACTUAL ALLOW	21,486,361.14
NON-COVERD CHARGES	1,185,130.69	TOTAL MEDICAID LIAB	2,085,784.50
		LESS: COB	478.94
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	2,083,625.56
		ALL OTHER	1,904,034.26
		FEE SCHEDULE-LAB	158,210.13
		INJECTABLE DRUGS	21,381.17

TOTAL NUMBER OF CLAIMS 5,340

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	885,957.23	0.00	OTHER LAB	246,176.24	1,990.00
MED/SURG SUPPLY	518,483.48	391.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,420,268.93	75,388.42	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,224,233.58	309,064.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,248.09	FEE SCHEDULE LAB	3,594,297.24	40,640.87
EKG/ECG	470,538.08	2,866.35	MRI SERVICES	300,515.30	26,018.95
IV THERAPY	1,425,046.73	65,710.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	963,162.44	103,412.71	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,726.67	20,519.88	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	581,656.42	0.00	AMBULANCE	0.00	0.00
GI SERVICES	76,014.27	18,369.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,353,571.53	11,987.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,512.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,373.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	927,677.15	165,311.65
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	814.34	1,383.62	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,360.92	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	888.00	7,414.24	TRAUMA RESPONSE	0.00	22,209.53
PSYCHIATRIC SERVICES	173,436.44	15,320.00	IMPL DEV CHARGE PATIENTS	33,925.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	617,045.20	178,373.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,167.80	15,228.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	260,215.97	28,023.73			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	132,177.82	58,524.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,364.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,272.87	0.00			

TOTAL ANCILLARY	23,572,145.64	1,185,130.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,572,145.64	1,185,130.69

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,207.91	ADJUSTMENTS	0.00
COVERED CHARGES	36,756.07	CONTRACTUAL ALLOW	13,547.13
NON-COVERD CHARGES	9,451.84	TOTAL MEDICAID LIAB	23,208.94
		LESS: COB	23,208.94
		LESS: COPAYMENT	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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309.00	0.00	OTHER LAB	5,970.00	0.00
MED/SURG SUPPLY	271.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,156.68	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,999.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,485.25	688.84
EKG/ECG	1,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,658.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,656.54	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,068.00	2,764.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,756.07	9,451.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,756.07	9,451.84

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,252,489.97	ADJUSTMENTS	326.64
COVERED CHARGES	1,220,834.20	CONTRACTUAL ALLOW	1,188,892.46
NON-COVERD CHARGES	31,655.77	TOTAL MEDICAID LIAB	31,941.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	30,864.74
		TOTAL NUMBER OF CLAIMS	571

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,138.48	0.00	OTHER LAB	7,594.00	0.00
MED/SURG SUPPLY	3,323.42	40.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,989.30	9,052.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,207.73	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,683.30	2,983.68
EKG/ECG	16,174.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	78,905.50	501.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	593,560.52	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,464.87	3,661.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	98.32	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,362.45	1,532.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,480.73	9,959.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,769.76	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,220,834.20	31,655.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,220,834.20	31,655.77

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,296.05	ADJUSTMENTS	0.00
COVERED CHARGES	95,147.99	CONTRACTUAL ALLOW	82,878.27
NON-COVERD CHARGES	2,148.06	TOTAL MEDICAID LIAB	12,269.72
		LESS: COB	0.00
		LESS: COPAYMENT	16.88
		REIMBURSEMENT	12,252.84

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,971.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,216.43	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	3,187.12	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,023.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,370.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,511.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,857.09	2,148.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,010.26	0.00			

TOTAL ANCILLARY	95,147.99	2,148.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	95,147.99	2,148.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,469,730.56	ADJUSTMENTS	2,009,314.27
COVERED CHARGES	34,606,659.93	CONTRACTUAL ALLOW	24,832,889.97
NON-COVERD CHARGES	863,070.63	TOTAL MEDICAID LIAB	9,773,769.96
		LESS: COB	94,126.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,679,643.17

TOTAL NUMBER OF ADMISSIONS 967

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,552	0	2,951,897.00	318,722.00
ROUTINE NURSERY	320	0	306,159.00	44,242.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,872	0	3,258,056.00	362,964.50
SPECIAL CARE SERVICES				
CCU	126	0	256,488.00	0.00
ICU	1,673	0	2,533,059.00	0.00
NICU	23	0	42,343.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	2,831,890.00	0.00
TOTAL ACCOMODATIONS	5,694	0	6,089,946.00	362,964.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
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SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,302,648.17	37,660.50	OTHER LAB	111,019.50	0.00
MED/SURG SUPPLY	1,505,910.98	25,757.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,807,826.50	22,074.00	EDUCATION & TRAINING	68,039.50	988.00
RADIOLOGY-DIAGNOSTIC	335,288.50	768.00	OTHER THERAPEUTIC SVC	0.00	720.00
CT SCAN	1,392,062.00	3,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156,421.00	2,991.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	197,288.00	0.00	MRI SERVICES	273,119.00	0.00
IV THERAPY	168,505.00	1,184.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,346,711.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	129,501.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,870,390.00	6,666.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	333,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	196,392.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	793,542.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	201,273.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	46,684.75
LABORATORY PATHOLOGIC	84,744.50	0.00	INJECTABLE DRUGS	278,972.25	0.00
RADIOLOGY THERAPEUTIC	10,325.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,068.50	10,614.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	92,529.50	717.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	438,970.50	6,718.34	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,990.50	149.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,066,932.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30,475.00
OTHER IMAGING SERVICE	229,055.50	24,716.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	248,514.50	236,733.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	64,030.00	23,961.00			
AUDIOLOGY	33,798.00	0.00			
CARDIOLOGY	1,105,828.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,310.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	574,042.00	16,821.50			

TOTAL ANCILLARY	28,516,713.93	500,106.13
TOTAL ACCOMODATIONS	6,089,946.00	362,964.50
TOTAL CHARGES	34,606,659.93	863,070.63

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SERVICE DATES 10/01/17 THROUGH 09/30/18
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	5918036000529	11/20/17 - 12/05/17	02/12/18	0.00	2,169.00	0.00	0.00	0.00
615	2218058008630	02/03/18 - 02/09/18	03/05/18	0.00	2,169.00	0.00	0.00	0.00
615	5918066000900	12/31/17 - 01/04/18	03/12/18	0.00	2,169.00	0.00	0.00	0.00
615	2018071013178	12/20/17 - 12/26/17	03/19/18	0.00	2,169.00	0.00	0.00	0.00
615	2018071013213	02/16/18 - 03/06/18	03/19/18	0.00	2,169.00	0.00	0.00	0.00
615	2018080051425	03/14/18 - 03/18/18	03/26/18	0.00	2,169.00	0.00	0.00	0.00
615	2218085001408	01/03/18 - 01/19/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	2018085013206	03/18/18 - 03/21/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	2018088057516	03/21/18 - 03/23/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	5918092000153	02/28/18 - 03/07/18	04/09/18	0.00	2,169.00	0.00	0.00	0.00
615	2218099001322	11/02/17 - 11/05/17	04/16/18	0.00	2,169.00	0.00	0.00	0.00
615	2218130003524	03/22/18 - 04/12/18	05/14/18	0.00	2,169.00	0.00	0.00	0.00
615	2218173015532	01/25/18 - 02/01/18	06/25/18	0.00	2,169.00	0.00	0.00	0.00
615	2018199045462	07/13/18 - 07/15/18	07/23/18	0.00	2,278.00	0.00	0.00	0.00
TOTAL				0.00	30,475.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
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VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	180,368.07	ADJUSTMENTS	0.00
COVERED CHARGES	177,103.07	CONTRACTUAL ALLOW	67,324.98
NON-COVERD CHARGES	3,265.00	TOTAL MEDICAID LIAB	109,778.09
		LESS: COB	109,778.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	19	0	16,090.00	1,371.00
ROUTINE NURSERY	9	0	7,631.00	1,894.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	28	0	23,721.00	3,265.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	4	0	7,348.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	7,348.00	0.00
TOTAL ACCOMODATIONS	32	0	31,069.00	3,265.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,980.50	0.00	OTHER LAB	1,860.00	0.00
MED/SURG SUPPLY	13,359.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,088.00	0.00	EDUCATION & TRAINING	150.00	0.00
RADIOLOGY-DIAGNOSTIC	634.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,678.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,352.00	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	17,858.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,682.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,605.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,259.00	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	2,420.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,152.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	337.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	27,788.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	963.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,868.00	0.00			

TOTAL ANCILLARY	146,034.07	0.00
TOTAL ACCOMODATIONS	31,069.00	3,265.00
TOTAL CHARGES	177,103.07	3,265.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,238,442.31	ADJUSTMENTS	894,792.61
COVERED CHARGES	13,089,356.84	CONTRACTUAL ALLOW	9,903,573.60
NON-COVERD CHARGES	2,149,085.47	TOTAL MEDICAID LIAB	3,185,783.24
		LESS: COB	12,357.36
		LESS: COPAYMENT	8,408.70
		REIMBURSEMENT	3,165,017.18
		ALL OTHER	2,626,021.70
		FEE SCHEDULE-LAB	325,619.65
		INJECTABLE DRUGS	213,375.83

TOTAL NUMBER OF CLAIMS 7,668

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,217,806.33	674.00	OTHER LAB	187,036.00	10,986.00
MED/SURG SUPPLY	262,404.76	833.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	393.00	4,916.00
RADIOLOGY-DIAGNOSTIC	448,887.00	56,744.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,498,810.50	577,635.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	12,753.00	FEE SCHEDULE LAB	1,853,905.75	191,538.00
EKG/ECG	242,602.00	10,441.00	MRI SERVICES	235,859.00	62,263.00
IV THERAPY	452,452.00	41,143.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	543,597.88	144,396.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100,276.50	96,511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	224,834.00	7,468.00	AMBULANCE	0.00	0.00
GI SERVICES	102,777.00	48,384.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,751,570.50	57,804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	300,138.00	0.00	DRUG-SPECIFIC/HOME IV	39,226.06	7,018.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,268,716.34	385,943.98
RADIOLOGY THERAPEUTIC	253,971.50	31,321.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,222.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	507.00	17,015.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,964.00	7,855.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,416.22	25,641.61
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,507.00
OTHER IMAGING SERVICE	638,097.50	94,891.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,980.50	42,182.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,521.00	30,316.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	232,055.00	114,122.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,306.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	852,245.00	54,558.50			

TOTAL ANCILLARY	13,089,356.84	2,149,085.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,089,356.84	2,149,085.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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
615	5218083002748	01/11/18 - 01/11/18	04/16/18	0.00	2,169.00	0.00	0.00	0.00
615	5918122000284	02/12/18 - 02/12/18	05/07/18	0.00	2,169.00	0.00	0.00	0.00
615	2318128000105	02/09/18 - 02/09/18	05/28/18	0.00	2,169.00	0.00	0.00	0.00
TOTAL				0.00	6,507.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	269,361.41	ADJUSTMENTS	0.00
COVERED CHARGES	185,417.43	CONTRACTUAL ALLOW	24,975.23
NON-COVERD CHARGES	83,943.98	TOTAL MEDICAID LIAB	160,442.20
		LESS: COB	160,304.20
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 113

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
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,148.89	0.00	OTHER LAB	3,795.00	310.00
MED/SURG SUPPLY	7,620.04	52.47	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	718.00
RADIOLOGY-DIAGNOSTIC	1,981.00	818.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,062.00	20,462.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	524.00	FEE SCHEDULE LAB	30,692.50	3,231.00
EKG/ECG	1,710.00	0.00	MRI SERVICES	3,597.00	8,512.00
IV THERAPY	9,869.50	1,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,778.00	18,384.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,511.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,756.00	333.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,622.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,226.00	4,968.75
RADIOLOGY THERAPEUTIC	9,529.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	438.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	50.00	1,707.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,783.50	11,705.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,232.00	1,962.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,038.00	5,719.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,416.00	2,439.00			

TOTAL ANCILLARY	185,417.43	83,943.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,417.43	83,943.98

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	223,820.43	ADJUSTMENTS	2,463.36
COVERED CHARGES	207,530.93	CONTRACTUAL ALLOW	188,925.19
NON-COVERD CHARGES	16,289.50	TOTAL MEDICAID LIAB	18,605.74
		LESS: COB	47.51
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	18,177.23
		TOTAL NUMBER OF CLAIMS	323

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,220.58	0.00	OTHER LAB	2,068.00	0.00
MED/SURG SUPPLY	3,321.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,486.50	1,048.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,759.00	6,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,963.50	4,688.00
EKG/ECG	3,221.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,306.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,854.00	206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,267.00	291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,501.25	2,478.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,050.00	1,375.50			
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	513.00	0.00			

TOTAL ANCILLARY	207,530.93	16,289.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	207,530.93	16,289.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,903.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,896.25	CONTRACTUAL ALLOW	365.62
NON-COVERD CHARGES	3,007.00	TOTAL MEDICAID LIAB	6,530.63
		LESS: COB	6,527.63
		LESS: COPAYMENT	3.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,977.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,830.00	30.00
EKG/ECG	190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	198.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,233.00	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	74.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,896.25	3,007.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,896.25	3,007.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,060,082.82	ADJUSTMENTS	414,842.17
COVERED CHARGES	6,328,108.14	CONTRACTUAL ALLOW	5,268,685.94
NON-COVERD CHARGES	731,974.68	TOTAL MEDICAID LIAB	1,059,422.20
		LESS: COB	5,495.58
		LESS: COPAYMENT	1,668.00
		REIMBURSEMENT	1,052,258.62

TOTAL NUMBER OF CLAIMS 191

GEORGIA 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	540,031.55	0.00	OTHER LAB	7,414.00	499.00
MED/SURG SUPPLY	123,914.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	491.00
RADIOLOGY-DIAGNOSTIC	50,275.00	3,192.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,220.00	40,825.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,021.50	FEE SCHEDULE LAB	79,307.75	8,396.00
EKG/ECG	4,542.00	3,230.00	MRI SERVICES	2,809.00	11,187.00
IV THERAPY	158,232.00	5,927.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	139,277.58	158,366.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,065.00	16,134.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,610.00	1,002.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,190.00	97.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,916.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,569,885.75	149,102.60
RADIOLOGY THERAPEUTIC	374,925.00	56,402.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,740.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	849.00	3,711.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,034.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	388.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	550,480.33	142,750.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,829.00	12,597.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,172.00	5,886.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,375.00	4,121.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	394,207.00	75,556.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	554.00	554.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,026.50	20,764.00			

TOTAL ANCILLARY	6,328,108.14	731,974.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,328,108.14	731,974.68

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,573,343.88	ADJUSTMENTS	120,937.42
COVERED CHARGES	1,371,683.74	CONTRACTUAL ALLOW	1,019,440.25
NON-COVERD CHARGES	201,660.14	TOTAL MEDICAID LIAB	352,243.49
		LESS: COB	35.76
		LESS: COPAYMENT	989.04
		REIMBURSEMENT	351,218.69
		ALL OTHER	331,742.69
		FEE SCHEDULE-LAB	17,238.81
		INJECTABLE DRUGS	2,237.19

TOTAL NUMBER OF CLAIMS 626

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,930.64	0.00	OTHER LAB	6,468.00	0.00
MED/SURG SUPPLY	47,067.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,906.50	211.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,799.00	48,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	222.00	1,341.00	FEE SCHEDULE LAB	80,117.50	3,780.50
EKG/ECG	5,501.00	1,140.00	MRI SERVICES	28,950.00	5,994.00
IV THERAPY	0.00	102.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	326,931.03	63,608.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,061.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,049.00	65,331.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,819.00	109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,007.18	5,947.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,615.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	46,140.47	0.00
LITHOTRIPSY	64,516.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,848.00	2,002.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,184.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,288.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,753.00	651.00			

TOTAL ANCILLARY	1,371,683.74	201,660.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,371,683.74	201,660.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,413.99	ADJUSTMENTS	0.00
COVERED CHARGES	34,791.64	CONTRACTUAL ALLOW	12,043.86
NON-COVERD CHARGES	6,622.35	TOTAL MEDICAID LIAB	22,747.78
		LESS: COB	22,729.78
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,199.25	0.00	OTHER LAB	499.00	0.00
MED/SURG SUPPLY	1,049.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,298.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,761.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	768.00	216.00
EKG/ECG	190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,853.90	6,106.10	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	6,060.00	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	6,166.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	625.75	300.25
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	320.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	34,791.64	6,622.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,791.64	6,622.35

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97.00	ADJUSTMENTS	0.00
COVERED CHARGES	97.00	CONTRACTUAL ALLOW	41.06
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	55.94
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	52.94
		TOTAL NUMBER OF CLAIMS	1

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	97.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	97.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	97.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	188,309.24	ADJUSTMENTS	26,002.20
COVERED CHARGES	170,820.38	CONTRACTUAL ALLOW	134,404.70
NON-COVERD CHARGES	17,488.86	TOTAL MEDICAID LIAB	36,415.68
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	36,400.68

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,062.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,222.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	655.00	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	566.00	20.00
EKG/ECG	0.00	190.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,821.14	16,432.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,989.00	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	11,468.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,401.75	846.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	76,641.65	0.00
LITHOTRIPSY	35,429.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,564.00	0.00			

TOTAL ANCILLARY	170,820.38	17,488.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	170,820.38	17,488.86

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,602,646.88	ADJUSTMENTS	234,437.35
COVERED CHARGES	16,034,877.00	CONTRACTUAL ALLOW	10,035,235.52
NON-COVERD CHARGES	1,567,769.88	TOTAL MEDICAID LIAB	5,999,641.48
		LESS: COB	84,590.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,915,050.85

TOTAL NUMBER OF ADMISSIONS 797

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,102	0	2,761,692.00	1,513,410.75
ROUTINE NURSERY	118	0	71,597.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,220	0	2,833,289.50	1,513,410.75
SPECIAL CARE SERVICES				
CCU	26	0	38,057.50	0.00
ICU	445	0	629,558.75	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	471	0	667,616.25	0.00
TOTAL ACCOMODATIONS	4,691	0	3,500,905.75	1,513,410.75

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	956,652.05	0.00	OTHER LAB	73,012.00	0.00
MED/SURG SUPPLY	1,236,074.66	2,034.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,072,190.03	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	260,409.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	437,635.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	300,248.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	108,453.00	0.00	MRI SERVICES	125,076.75	1,148.50
IV THERAPY	95,788.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	939,812.25	6,460.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	68,901.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,645.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	583,683.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	152,547.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	709,348.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,887.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	7,059.50
LABORATORY PATHOLOGIC	155,580.75	0.00	INJECTABLE DRUGS	2,115,855.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	160,067.19	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	30,942.73	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	116,806.50	2,163.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	785.50	2,570.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	568,719.25	0.00
LITHOTRIPSY	11,944.00	0.00	NO CC/INVALID REV CODE	0.00	3,360.00
OTHER IMAGING SERVICE	53,948.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,061.00	10,977.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,220.50	12,541.75			
AUDIOLOGY	15,528.00	0.00			
CARDIOLOGY	322,940.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,417.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	156,788.45	6,044.00			

TOTAL ANCILLARY	12,533,971.25	54,359.13
TOTAL ACCOMODATIONS	3,500,905.75	1,513,410.75
TOTAL CHARGES	16,034,877.00	1,567,769.88

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 01/01/18 THROUGH 12/31/18
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	2019022000081	12/03/18 - 12/12/18	01/28/19	0.00	1,680.00	0.00	0.00	0.00
615	2219043008830	11/18/18 - 11/21/18	02/18/19	0.00	1,680.00	0.00	0.00	0.00
TOTAL				0.00	3,360.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	94,248.34	ADJUSTMENTS	0.00
COVERED CHARGES	81,710.34	CONTRACTUAL ALLOW	28,056.77
NON-COVERD CHARGES	12,538.00	TOTAL MEDICAID LIAB	53,653.57
		LESS: COB	53,653.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	34	0	22,679.00	12,349.00
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	34	0	22,679.00	12,349.00
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	34	0	22,679.00	12,349.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,607.33	0.00	OTHER LAB	26.25	0.00
MED/SURG SUPPLY	2,543.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,226.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	535.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,440.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	290.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,014.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,025.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,447.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,322.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,171.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,378.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	404.25	0.00	INJECTABLE DRUGS	14,848.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,855.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	967.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,928.00	189.00			

TOTAL ANCILLARY	59,031.34	189.00
TOTAL ACCOMODATIONS	22,679.00	12,349.00
TOTAL CHARGES	81,710.34	12,538.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,744,096.28	ADJUSTMENTS	451,971.51
COVERED CHARGES	7,672,040.50	CONTRACTUAL ALLOW	5,769,181.09
NON-COVERD CHARGES	2,072,055.78	TOTAL MEDICAID LIAB	1,902,859.41
		LESS: COB	8,543.10
		LESS: COPAYMENT	4,837.20
		REIMBURSEMENT	1,889,479.11
		ALL OTHER	1,699,758.72
		FEE SCHEDULE-LAB	161,906.47
		INJECTABLE DRUGS	27,813.92

TOTAL NUMBER OF CLAIMS 3,771

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,764.60	3,616.34	OTHER LAB	76,691.78	703.50
MED/SURG SUPPLY	488,095.28	43,833.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	409,268.25	45,751.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	572,360.75	106,971.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152,427.00	18,564.50	FEE SCHEDULE LAB	1,140,860.83	136,993.41
EKG/ECG	151,975.00	4,205.00	MRI SERVICES	110,656.50	26,133.25
IV THERAPY	299,879.38	8,966.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	468,345.33	369,539.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	350.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,736.75	4,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	368,744.75	607.50	AMBULANCE	0.00	0.00
GI SERVICES	48,087.75	31,310.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,124,187.50	17,640.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	85,776.25	525.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	244,585.88	1,043,707.58
RADIOLOGY THERAPEUTIC	23,164.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,787.50	8,058.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,947.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,412.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,390.86	23,671.68	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	53.00	IMPL DEV CHARGE PATIENTS	58,359.00	14,722.75
LITHOTRIPSY	11,944.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	78,938.00	14,133.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,682.25	5,722.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,373.00	53,199.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	179,425.50	67,173.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,557.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,624.56	17,251.06			

TOTAL ANCILLARY	7,672,040.50	2,072,055.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,672,040.50	2,072,055.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,869.56	ADJUSTMENTS	0.00
COVERED CHARGES	82,410.59	CONTRACTUAL ALLOW	45,730.72
NON-COVERD CHARGES	38,458.97	TOTAL MEDICAID LIAB	36,679.87
		LESS: COB	36,599.43
		LESS: COPAYMENT	80.44
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	899.60	0.00	OTHER LAB	1,149.75	0.00
MED/SURG SUPPLY	5,866.75	222.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,728.25	1,723.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,242.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,965.75	1,835.00
EKG/ECG	1,885.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,649.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,173.37	9,554.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,434.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,343.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,372.50	375.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,187.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,104.51	1,254.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	446.11	297.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,877.50	0.00	IMPL DEV CHARGE PATIENTS	1,142.50	9,639.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	335.00	452.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	519.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193.25	0.00			

TOTAL ANCILLARY	82,410.59	38,458.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,410.59	38,458.97

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	219,150.68	ADJUSTMENTS	3,970.18
COVERED CHARGES	210,062.54	CONTRACTUAL ALLOW	197,822.70
NON-COVERD CHARGES	9,088.14	TOTAL MEDICAID LIAB	12,239.84
		LESS: COB	159.10
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	11,612.74
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,955.72	1.92	OTHER LAB	572.25	0.00
MED/SURG SUPPLY	4,362.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,221.25	2,885.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,156.50	2,178.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,039.25	1,539.00
EKG/ECG	3,480.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,720.50	206.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	546.00	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	131,752.00	375.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,084.32	1,481.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,073.50	357.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4.00	0.00			

TOTAL ANCILLARY	210,062.54	9,088.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	210,062.54	9,088.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,663.67	ADJUSTMENTS	0.00
COVERED CHARGES	5,574.17	CONTRACTUAL ALLOW	4,469.73
NON-COVERD CHARGES	2,089.50	TOTAL MEDICAID LIAB	1,104.44
		LESS: COB	1,098.44
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	168.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201.50	201.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,308.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,024.00	0.00
EKG/ECG	145.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	44.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,892.75	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	95.50	127.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	452.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,574.17	2,089.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,574.17	2,089.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,574,207.41	ADJUSTMENTS	104,351.29
COVERED CHARGES	2,145,757.72	CONTRACTUAL ALLOW	1,865,727.28
NON-COVERD CHARGES	428,449.69	TOTAL MEDICAID LIAB	280,030.44
		LESS: COB	0.00
		LESS: COPAYMENT	190.35
		REIMBURSEMENT	279,840.09
		TOTAL NUMBER OF CLAIMS	51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,680.60	32.25	OTHER LAB	26.25	26.25
MED/SURG SUPPLY	252,223.55	24,936.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,690.25	4,769.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,390.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,002.27	FEE SCHEDULE LAB	15,729.25	2,430.50
EKG/ECG	1,595.00	145.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,702.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	815,502.37	61,285.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,012.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	211,480.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,509.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,882.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,198.95	17,761.26
RADIOLOGY THERAPEUTIC	1,966.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	879.53	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	283.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	517,169.00	199,458.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,680.00	335.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,836.50	181.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,440.25	115,206.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,758.00	0.00			

TOTAL ANCILLARY	2,145,757.72	428,449.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,145,757.72	428,449.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,935,446.26	ADJUSTMENTS	984,377.75
COVERED CHARGES	28,696,522.24	CONTRACTUAL ALLOW	21,409,579.84
NON-COVERD CHARGES	238,924.02	TOTAL MEDICAID LIAB	7,286,942.40
		LESS: COB	111,627.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,175,314.58

TOTAL NUMBER OF ADMISSIONS 458

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,416	0	1,486,800.00	48,357.00
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	1,416	0	1,486,800.00	48,357.00
SPECIAL CARE SERVICES				
CCU	267	0	914,808.00	0.00
ICU	1,721	0	3,763,270.00	4,581.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,988	0	4,678,078.00	4,581.00
TOTAL ACCOMODATIONS	3,404	0	6,164,878.00	52,938.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,286,414.00	1,306.00	OTHER LAB	130,625.50	0.00
MED/SURG SUPPLY	1,033,597.00	3,520.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,917,844.68	8,365.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	721,576.00	436.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,043,447.00	51,395.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	324,392.02	248.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	88,842.00	0.00	MRI SERVICES	319,791.00	0.00
IV THERAPY	381,580.00	1,613.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,838,368.00	10,799.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,673,070.00	6.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	501,804.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,902.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	676,788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	251,596.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	44,663.00	0.00	INJECTABLE DRUGS	2,967,717.00	452.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,475.93	0.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	152,110.11	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	276,247.00	7,047.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	2,102,681.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,700.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	412,524.00	10,069.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,649.00	90,730.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	770,061.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,709.00	0.00			

TOTAL ANCILLARY	22,531,644.24	185,986.02
TOTAL ACCOMODATIONS	6,164,878.00	52,938.00
TOTAL CHARGES	28,696,522.24	238,924.02

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,164.03	ADJUSTMENTS	0.00
COVERED CHARGES	203,600.03	CONTRACTUAL ALLOW	141,410.83
NON-COVERD CHARGES	5,564.00	TOTAL MEDICAID LIAB	62,189.20
		LESS: COB	62,189.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	13,650.00	416.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	13,650.00	416.00
SPECIAL CARE SERVICES				
CCU	2	0	7,060.00	0.00
ICU	19	0	26,866.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	33,926.00	0.00
TOTAL ACCOMODATIONS	34	0	47,576.00	416.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,908.00	0.00	OTHER LAB	2,211.00	0.00
MED/SURG SUPPLY	4,562.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,532.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,903.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,588.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,288.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,061.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,201.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,317.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,651.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	727.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,399.00	4,698.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	7,016.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	436.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	730.00	450.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,701.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	156,024.03	5,148.00
TOTAL ACCOMODATIONS	47,576.00	416.00
TOTAL CHARGES	203,600.03	5,564.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,199,401.42	ADJUSTMENTS	241,549.55
COVERED CHARGES	8,245,104.12	CONTRACTUAL ALLOW	7,029,140.19
NON-COVERD CHARGES	954,297.30	TOTAL MEDICAID LIAB	1,215,963.93
		LESS: COB	2,240.73
		LESS: COPAYMENT	2,463.00
		REIMBURSEMENT	1,211,260.20
		ALL OTHER	1,149,835.15
		FEE SCHEDULE-LAB	61,387.83
		INJECTABLE DRUGS	37.22

TOTAL NUMBER OF CLAIMS 2,493

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	527,172.00	952.00	OTHER LAB	83,876.00	737.00
MED/SURG SUPPLY	143,683.00	1,150.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	404,788.00	20,921.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,051,258.00	158,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,232.00	25,217.26	FEE SCHEDULE LAB	557,201.80	44,166.62
EKG/ECG	67,344.00	1,104.00	MRI SERVICES	256,618.00	33,785.00
IV THERAPY	723,794.00	16,608.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,714.62	221,360.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	253,863.00	7,204.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,993.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	53,952.00	19,972.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,437,832.50	11,641.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,229.00	56.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,211.00	4,979.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511.00	2,118.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,171.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	30.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	219,789.00	32,975.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	116,927.00	15,607.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,963.00	3,183.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	254,092.00	184,713.00			
AUDIOLOGY	63,940.00	41,633.00			
CARDIOLOGY	277,451.00	92,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,713.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,026.20	7,272.00			

TOTAL ANCILLARY	8,245,104.12	954,297.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,245,104.12	954,297.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	146,530.96	ADJUSTMENTS	0.00
COVERED CHARGES	110,295.96	CONTRACTUAL ALLOW	76,888.56
NON-COVERD CHARGES	36,235.00	TOTAL MEDICAID LIAB	33,407.40
		LESS: COB	33,383.40
		LESS: COPAYMENT	24.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,947.00	53.00	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	3,363.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,473.00	2,946.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,009.00	488.00
EKG/ECG	1,288.00	0.00	MRI SERVICES	16,440.00	9,428.00
IV THERAPY	9,247.00	508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,751.00	5,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,505.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,898.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,660.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,030.00	1,458.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,520.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	635.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,629.00			
AUDIOLOGY	2,570.00	4,015.00			
CARDIOLOGY	723.00	1,185.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,353.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,038.96	0.00			

TOTAL ANCILLARY	110,295.96	36,235.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	110,295.96	36,235.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	243,476.00	ADJUSTMENTS	588.34
COVERED CHARGES	240,128.00	CONTRACTUAL ALLOW	231,233.54
NON-COVERD CHARGES	3,348.00	TOTAL MEDICAID LIAB	8,894.46
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	8,561.46
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,887.00	0.00	OTHER LAB	3,454.00	0.00
MED/SURG SUPPLY	118.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,931.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,902.00	1,473.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,469.00	1,621.00
EKG/ECG	2,208.00	0.00	MRI SERVICES	5,288.00	0.00
IV THERAPY	30,463.00	254.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,118.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	119,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,912.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,026.00	0.00			

TOTAL ANCILLARY	240,128.00	3,348.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	240,128.00	3,348.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,813.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,393.00	CONTRACTUAL ALLOW	7,453.58
NON-COVERD CHARGES	420.00	TOTAL MEDICAID LIAB	1,939.42
		LESS: COB	1,933.42
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	2,410.00	367.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,226.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,364.00	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	393.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,393.00	420.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,393.00	420.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	421,041.02	ADJUSTMENTS	21,681.64
COVERED CHARGES	351,412.66	CONTRACTUAL ALLOW	302,265.66
NON-COVERD CHARGES	69,628.36	TOTAL MEDICAID LIAB	49,147.00
		LESS: COB	5,424.38
		LESS: COPAYMENT	33.88
		REIMBURSEMENT	43,688.74

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,870.00	229.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52,524.00	32.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,601.00	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	597.02	FEE SCHEDULE LAB	4,932.00	0.00
EKG/ECG	552.00	184.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,739.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,034.00	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	10,110.00	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	142,174.00	2,870.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	265.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,177.66	65,380.34			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	966.00	336.00			

TOTAL ANCILLARY	351,412.66	69,628.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	351,412.66	69,628.36

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,575,415.20	ADJUSTMENTS	1,755,874.83
COVERED CHARGES	28,703,450.37	CONTRACTUAL ALLOW	19,084,287.15
NON-COVERD CHARGES	1,871,964.83	TOTAL MEDICAID LIAB	9,619,163.22
		LESS: COB	254,252.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,364,910.96

TOTAL NUMBER OF ADMISSIONS 525

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,760	0	3,684,206.00	652,126.00
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	2,760	0	3,684,206.00	652,126.00
SPECIAL CARE SERVICES				
CCU	147	0	878,449.00	24,572.00
ICU	818	0	3,830,338.00	58,367.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	965	0	4,708,787.00	82,939.00
TOTAL ACCOMODATIONS	3,725	0	8,392,993.00	735,065.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,007,281.51	13,820.51	OTHER LAB	117,563.00	1,872.00
MED/SURG SUPPLY	1,132,350.67	70,315.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,771,079.00	109,363.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	493,899.64	2,698.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	941,565.00	1,439.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	193,050.45	4,034.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	90,775.00	924.00	MRI SERVICES	393,326.00	8,958.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,604,188.00	60,576.00	DURABLE MED. EQUIP.	0.00	6,017.55
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	740,892.00	5,743.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	659,147.00	10,062.00	AMBULANCE	0.00	0.00
GI SERVICES	235,903.00	1,242.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	665,979.00	3,471.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	189,844.00	1,280.00	DRUG-SPECIFIC/HOME IV	0.00	40,760.20
LABORATORY PATHOLOGIC	165,492.00	339.00	INJECTABLE DRUGS	2,336,071.76	547,223.05
RADIOLOGY THERAPEUTIC	43,543.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	143,404.12	5,314.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,236.21	2,079.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	429,110.00	5,967.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,952.00	137.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,192,011.91	4,356.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	140,629.00
OTHER IMAGING SERVICE	92,587.00	2,253.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	339,688.00	56,167.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,782.00	5,580.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,111,859.10	24,280.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,489.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,388.00	0.00			

TOTAL ANCILLARY	20,310,457.37	1,136,899.83
TOTAL ACCOMODATIONS	8,392,993.00	735,065.00
TOTAL CHARGES	28,703,450.37	1,871,964.83

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 09/01/17 THROUGH 08/31/18
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	2017278048541	09/26/17 - 09/27/17	10/09/17	0.00	2,698.00	0.00	0.00	0.00
614	2017341097170	10/17/17 - 11/02/17	12/11/17	0.00	8,958.00	0.00	0.00	0.00
615	2318011000162	11/09/17 - 11/16/17	02/05/18	0.00	8,958.00	0.00	2,953.49	0.00
615	9718024981025	09/15/17 - 09/17/17	01/29/18	0.00	8,958.00	0.00	1,611.25	0.00
615	2018058045292	02/14/18 - 02/19/18	03/05/18	0.00	13,437.00	0.00	0.00	0.00
615	9818063000153	10/28/17 - 11/30/17	03/12/18	0.00	2,698.00	0.00	0.00	0.00
614	2318078000132	10/09/17 - 10/12/17	03/26/18	0.00	4,479.00	0.00	1,368.97	0.00
615	2018089056555	01/14/18 - 02/12/18	04/09/18	0.00	5,396.00	0.00	0.00	0.00
615	2018152085803	05/21/18 - 05/27/18	06/11/18	0.00	5,396.00	0.00	0.00	0.00
614	2318159000306	04/19/18 - 04/27/18	07/02/18	0.00	5,396.00	0.00	0.00	0.00
614	2318190000028	05/31/18 - 06/08/18	07/23/18	0.00	2,698.00	0.00	5,465.32	0.00
615	2018197041538	07/06/18 - 07/11/18	07/23/18	0.00	7,177.00	0.00	0.00	0.00
614	5218206000350	12/22/17 - 01/26/18	07/30/18	0.00	2,485.00	0.00	0.00	0.00
614	2318232000123	04/09/18 - 04/23/18	09/10/18	0.00	2,698.00	0.00	2,782.89	0.00
615	2018245001768	08/22/18 - 08/28/18	09/10/18	0.00	2,698.00	0.00	0.00	0.00
614	2318283000420	10/22/17 - 11/15/17	11/12/18	0.00	5,396.00	0.00	0.00	0.00
614	2318296000443	02/07/18 - 03/09/18	11/19/18	0.00	4,479.00	0.00	0.00	0.00
614	2018299079640	04/01/18 - 05/01/18	11/05/18	0.00	5,396.00	0.00	0.00	0.00
615	2318313000212	07/27/18 - 07/30/18	12/10/18	0.00	8,958.00	0.00	0.00	0.00
615	2019038106587	07/13/18 - 07/14/18	02/11/19	0.00	8,958.00	0.00	0.00	0.00
614	2319092000053	04/07/18 - 04/11/18	04/08/19	0.00	8,958.00	0.00	2,168.97	0.00
615	2219144006854	06/28/18 - 07/06/18	05/27/19	0.00	2,698.00	0.00	0.00	0.00
615	2019178079219	06/04/18 - 06/06/18	07/01/19	0.00	8,958.00	0.00	0.00	0.00
615	2219203007459	11/08/17 - 12/14/17	07/29/19	0.00	2,698.00	0.00	0.00	0.00
TOTAL				0.00	140,629.00	0.00	16,350.89	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	140,609.98	ADJUSTMENTS	0.00
COVERED CHARGES	139,083.98	CONTRACTUAL ALLOW	44,237.86
NON-COVERD CHARGES	1,526.00	TOTAL MEDICAID LIAB	94,846.12
		LESS: COB	94,846.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	20,454.00	1,526.00
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	20,454.00	1,526.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	6,143.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,143.00	0.00
TOTAL ACCOMODATIONS	15	0	26,597.00	1,526.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,458.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,801.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,232.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,011.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,086.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	154.00	0.00	MRI SERVICES	13,437.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,210.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,243.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,373.00	0.00	INJECTABLE DRUGS	3,891.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,290.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	8,157.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	383.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,486.98	0.00
TOTAL ACCOMODATIONS	26,597.00	1,526.00
TOTAL CHARGES	139,083.98	1,526.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,259,930.22	ADJUSTMENTS	136,591.71
COVERED CHARGES	4,479,762.72	CONTRACTUAL ALLOW	3,650,013.18
NON-COVERD CHARGES	1,780,167.50	TOTAL MEDICAID LIAB	829,749.54
		LESS: COB	314.12
		LESS: COPAYMENT	2,715.33
		REIMBURSEMENT	826,720.09
		ALL OTHER	755,332.61
		FEE SCHEDULE-LAB	59,009.61
		INJECTABLE DRUGS	12,377.87

TOTAL NUMBER OF CLAIMS 1,593

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,055.00	51,331.51	OTHER LAB	76,282.00	0.00
MED/SURG SUPPLY	115,483.00	49.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141,716.00	84,142.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	480,614.00	303,165.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,661.00	FEE SCHEDULE LAB	538,246.00	44,129.00
EKG/ECG	44,609.00	2,156.00	MRI SERVICES	244,617.00	221,305.00
IV THERAPY	2,450.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	522,983.00	147,254.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,741.00	3,519.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,204.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	144,061.00	74,291.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	755,325.00	10,261.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93,712.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	196,422.57	70,067.81
RADIOLOGY THERAPEUTIC	136,898.00	232,125.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,998.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,760.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	37,791.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,759.00	415.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,780.00	73,634.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	57,363.00
OTHER IMAGING SERVICE	240,675.00	96,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,492.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,328.00	115,333.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	319,806.15	142,456.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,547.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,957.00	2,527.00			

TOTAL ANCILLARY	4,479,762.72	1,780,167.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,479,762.72	1,780,167.50

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 09/01/17 THROUGH 08/31/18
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	2017283097273	10/02/17 - 10/02/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017283097273	10/02/17 - 10/02/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017360065275	12/15/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	2017360065275	12/15/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	2018114002905	04/14/18 - 04/14/18	04/30/18	0.00	2,698.00	0.00	0.00	0.00
615	2018114002905	04/14/18 - 04/14/18	04/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018122080318	04/25/18 - 04/25/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018122080318	04/25/18 - 04/25/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2218207001996	06/17/18 - 06/17/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2218207001996	06/17/18 - 06/17/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018212069901	07/17/18 - 07/17/18	08/06/18	0.00	4,479.00	0.00	0.00	0.00
615	2018212069901	07/17/18 - 07/17/18	08/06/18	0.00	4,479.00	0.00	0.00	0.00
615	2018254077235	08/28/18 - 08/28/18	09/17/18	0.00	4,479.00	0.00	0.00	0.00
615	2018254077235	08/28/18 - 08/28/18	09/17/18	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	57,363.00	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	240,532.12	ADJUSTMENTS	0.00
COVERED CHARGES	123,344.79	CONTRACTUAL ALLOW	43,897.19
NON-COVERD CHARGES	117,187.33	TOTAL MEDICAID LIAB	79,447.60
		LESS: COB	79,349.88
		LESS: COPAYMENT	97.72
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,645.78	6,806.09	OTHER LAB	2,808.00	0.00
MED/SURG SUPPLY	7,553.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,559.00	3,474.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,471.00	22,492.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,579.00	1,954.00
EKG/ECG	616.00	308.00	MRI SERVICES	0.00	40,311.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,695.00	17,290.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	354.00	177.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,628.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,875.00	475.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,649.01	1,503.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,989.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	108.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,315.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,528.00	1,010.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,667.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,382.00	12,308.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,474.00	0.00			

TOTAL ANCILLARY	123,344.79	117,187.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,344.79	117,187.33

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,553.39	ADJUSTMENTS	192.39
COVERED CHARGES	25,485.08	CONTRACTUAL ALLOW	23,885.19
NON-COVERD CHARGES	8,068.31	TOTAL MEDICAID LIAB	1,599.89
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	1,518.89
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	588.00	372.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,276.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,150.00	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	19,651.00	258.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,385.08	162.31
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	587.00	0.00			

TOTAL ANCILLARY	25,485.08	8,068.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,485.08	8,068.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,964.33	ADJUSTMENTS	0.00
COVERED CHARGES	2,894.33	CONTRACTUAL ALLOW	1,766.31
NON-COVERD CHARGES	70.00	TOTAL MEDICAID LIAB	1,128.02
		LESS: COB	1,128.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.33	70.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.00	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	1,228.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	312.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,337.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,894.33	70.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,894.33	70.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	413,682.43	ADJUSTMENTS	17,499.69
COVERED CHARGES	310,599.72	CONTRACTUAL ALLOW	263,885.88
NON-COVERD CHARGES	103,082.71	TOTAL MEDICAID LIAB	46,713.84
		LESS: COB	0.00
		LESS: COPAYMENT	41.38
		REIMBURSEMENT	46,672.46

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,486.95	2,291.08	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,557.00	64.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	534.00	21,708.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,693.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,438.00	260.00
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	93,077.00	2,947.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,399.00	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	1,100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,448.17	2,000.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,334.60	63,296.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	104.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	262.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,811.00	7,823.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	310,599.72	103,082.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	310,599.72	103,082.71

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,491,666.73	ADJUSTMENTS	338,304.85
COVERED CHARGES	12,724,337.73	CONTRACTUAL ALLOW	8,572,532.14
NON-COVERD CHARGES	767,329.00	TOTAL MEDICAID LIAB	4,151,805.59
		LESS: COB	67,562.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,084,243.42

TOTAL NUMBER OF ADMISSIONS 427

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,163	0	1,343,396.00	68,952.00
ROUTINE NURSERY	229	0	251,386.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,392	0	1,594,782.00	68,952.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	850	0	1,900,580.00	0.00
NICU	3	0	7,296.00	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	853	0	1,907,876.00	0.00
TOTAL ACCOMODATIONS	2,245	0	3,502,658.00	68,952.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,177,895.95	0.00	OTHER LAB	116,089.00	0.00
MED/SURG SUPPLY	475,574.16	6,263.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	742,581.86	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	281,293.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	534,493.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,149.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	131,733.00	0.00	MRI SERVICES	176,227.00	0.00
IV THERAPY	220,549.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,282,982.00	24,707.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	105,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	853,380.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	337,174.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	56,158.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	610,986.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	220,365.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	37,253.00	0.00	INJECTABLE DRUGS	1,645.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	51,117.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	41,715.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	116,223.00	2,039.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	958.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,498.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	115,575.00
OTHER IMAGING SERVICE	87,090.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	94,208.00	7,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,570.00	6,614.00			
AUDIOLOGY	685.00	0.00			
CARDIOLOGY	497,259.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,460.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,448.00	0.00			

TOTAL ANCILLARY	9,221,679.73	698,377.00
TOTAL ACCOMODATIONS	3,502,658.00	68,952.00
TOTAL CHARGES	12,724,337.73	767,329.00

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 07/01/17 THROUGH 06/30/18
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	2017221096221	07/12/17 - 07/16/17	08/14/17	0.00	2,458.00	0.00	0.00	0.00
615	2017221096259	07/18/17 - 07/20/17	08/14/17	0.00	2,221.00	0.00	0.00	0.00
614	2017258066958	08/25/17 - 08/30/17	09/25/17	0.00	872.00	0.00	0.00	0.00
615	2017258066958	08/25/17 - 08/30/17	09/25/17	0.00	2,221.00	0.00	0.00	0.00
614	5917275000920	09/14/17 - 09/20/17	10/09/17	0.00	2,998.00	0.00	0.00	0.00
615	2317285000173	09/02/17 - 09/05/17	11/20/17	0.00	4,430.00	0.00	2,222.29	0.00
615	2317293000148	07/29/17 - 08/11/17	12/04/17	0.00	2,221.00	0.00	2,704.33	0.00
614	5917297000411	09/06/17 - 09/11/17	10/30/17	0.00	4,602.00	0.00	0.00	0.00
615	5917306000105	10/05/17 - 10/26/17	11/06/17	0.00	2,221.00	0.00	0.00	0.00
618	5917306000105	10/05/17 - 10/26/17	11/06/17	0.00	2,677.00	0.00	0.00	0.00
614	2017324043529	10/24/17 - 11/03/17	11/27/17	0.00	2,458.00	0.00	0.00	0.00
615	2217332002170	10/31/17 - 11/02/17	12/04/17	0.00	2,221.00	0.00	0.00	0.00
615	2017340079555	11/19/17 - 11/24/17	12/11/17	0.00	2,221.00	0.00	0.00	0.00
614	2017342064809	11/14/17 - 11/15/17	12/18/17	0.00	2,458.00	0.00	0.00	0.00
614	2017346070984	08/01/17 - 08/04/17	12/18/17	0.00	2,458.00	0.00	0.00	0.00
614	2017364001361	11/27/17 - 12/01/17	01/08/18	0.00	1,287.00	0.00	0.00	0.00
614	2017364003930	12/04/17 - 12/13/17	01/08/18	0.00	1,287.00	0.00	0.00	0.00
615	2018009067746	12/15/17 - 12/31/17	01/15/18	0.00	2,221.00	0.00	0.00	0.00
615	2018015020400	12/16/17 - 12/20/17	01/22/18	0.00	2,221.00	0.00	0.00	0.00
615	9718052981003	11/25/17 - 01/02/18	02/26/18	0.00	4,442.00	0.00	0.00	0.00
615	2318059000083	01/12/18 - 01/15/18	03/19/18	0.00	2,221.00	0.00	2,015.14	0.00
615	2218080002972	11/17/17 - 11/24/17	03/26/18	0.00	2,221.00	0.00	0.00	0.00
614	2218080003151	01/18/18 - 01/19/18	03/26/18	0.00	2,455.00	0.00	0.00	0.00
615	2018092036680	03/01/18 - 03/03/18	04/09/18	0.00	2,221.00	0.00	0.00	0.00
614	2018092036800	03/14/18 - 03/16/18	04/09/18	0.00	2,669.00	0.00	0.00	0.00
614	2018101094248	03/18/18 - 03/21/18	04/16/18	0.00	2,455.00	0.00	0.00	0.00
614	2018101094261	03/17/18 - 03/20/18	04/16/18	0.00	3,840.00	0.00	0.00	0.00
615	2018101094267	03/16/18 - 03/17/18	04/16/18	0.00	4,430.00	0.00	0.00	0.00
615	2318116000274	03/20/18 - 03/22/18	05/07/18	0.00	2,221.00	0.00	1,704.72	0.00
614	2018122084714	04/12/18 - 04/14/18	05/07/18	0.00	2,458.00	0.00	0.00	0.00
615	2018127030146	04/10/18 - 04/11/18	05/14/18	0.00	2,221.00	0.00	0.00	0.00
615	2018128074341	04/18/18 - 04/21/18	05/14/18	0.00	2,221.00	0.00	0.00	0.00
615	2018130109742	09/15/17 - 09/17/17	05/14/18	0.00	2,221.00	0.00	0.00	0.00
614	2018143067361	05/05/18 - 05/17/18	05/28/18	0.00	2,669.00	0.00	0.00	0.00
614	2218162004123	03/08/18 - 03/21/18	06/25/18	0.00	5,151.00	0.00	0.00	0.00
614	2018185036789	06/12/18 - 06/20/18	07/09/18	0.00	2,998.00	0.00	0.00	0.00
614	2018185036908	06/13/18 - 06/17/18	07/09/18	0.00	2,669.00	0.00	0.00	0.00
614	2018192077845	05/14/18 - 05/22/18	07/16/18	0.00	4,602.00	0.00	0.00	0.00
615	2218198000182	05/08/18 - 05/24/18	07/23/18	0.00	2,221.00	0.00	0.00	0.00
614	5918200000503	04/20/18 - 04/25/18	07/23/18	0.00	1,458.00	0.00	0.00	0.00
614	2218204006167	06/25/18 - 07/03/18	07/30/18	0.00	2,669.00	0.00	0.00	0.00
614	5918213000781	06/13/18 - 06/22/18	08/06/18	0.00	3,410.00	0.00	0.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2018227087514	06/12/18 - 06/15/18	08/20/18	0.00	1,458.00	0.00	0.00	0.00
615	2019189033534	06/30/18 - 07/03/18	07/15/19	0.00	2,221.00	0.00	0.00	0.00
TOTAL				0.00	115,575.00	0.00	8,646.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	217,085.51	ADJUSTMENTS	0.00
COVERED CHARGES	210,456.01	CONTRACTUAL ALLOW	115,959.41
NON-COVERD CHARGES	6,629.50	TOTAL MEDICAID LIAB	94,496.60
		LESS: COB	94,496.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	36	0	41,688.00	2,088.00
ROUTINE NURSERY	5	0	9,096.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	41	0	50,784.00	2,088.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	16,662.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	16,662.00	0.00
TOTAL ACCOMODATIONS	48	0	67,446.00	2,088.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,511.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,018.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,516.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,094.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,372.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,766.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,796.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,368.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,520.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,263.00	0.00	INJECTABLE DRUGS	20,191.17	169.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,641.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,795.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	143,010.01	4,541.50
TOTAL ACCOMODATIONS	67,446.00	2,088.00
TOTAL CHARGES	210,456.01	6,629.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,852,629.13	ADJUSTMENTS	252,142.55
COVERED CHARGES	11,444,255.46	CONTRACTUAL ALLOW	9,086,680.79
NON-COVERD CHARGES	1,408,373.67	TOTAL MEDICAID LIAB	2,357,574.67
		LESS: COB	5,681.20
		LESS: COPAYMENT	4,693.76
		REIMBURSEMENT	2,347,199.71
		ALL OTHER	1,970,307.27
		FEE SCHEDULE-LAB	187,603.32
		INJECTABLE DRUGS	189,289.12

TOTAL NUMBER OF CLAIMS 4,927

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,313.36	4.40	OTHER LAB	108,592.00	1,830.00
MED/SURG SUPPLY	212,607.75	115,167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,848.00	522.00
RADIOLOGY-DIAGNOSTIC	594,785.00	22,339.00	OTHER THERAPEUTIC SVC	0.00	835.00
CT SCAN	1,091,958.00	105,156.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,907.00	18,663.00	FEE SCHEDULE LAB	864,179.17	42,704.64
EKG/ECG	203,475.00	16,820.00	MRI SERVICES	479,734.00	54,345.00
IV THERAPY	709,570.00	90,009.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,286,746.95	188,808.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,752.00	25,741.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	445,986.00	23,478.00	AMBULANCE	0.00	0.00
GI SERVICES	200,942.00	32,232.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,249,920.00	15,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	465,502.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	839,963.62	211,308.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	189.00	8,904.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,985.00	1,490.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,974.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	119,599.00	8,952.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,996.00	180,441.00
LITHOTRIPSY	15,623.00	0.00	NO CC/INVALID REV CODE	0.00	8,884.00
OTHER IMAGING SERVICE	258,336.00	46,519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,221.00	10,304.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	177,636.00	53,453.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	438,176.00	119,199.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	187,706.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,006.61	0.00			

TOTAL ANCILLARY	11,444,255.46	1,408,373.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,444,255.46	1,408,373.67

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 07/01/17 THROUGH 06/30/18
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	2018032070791	12/15/17 - 12/15/17	02/05/18	0.00	2,221.00	0.00	0.00	0.00
615	2018061002963	01/20/18 - 01/20/18	03/05/18	0.00	2,221.00	0.00	0.00	0.00
615	5918093001173	03/16/18 - 03/16/18	04/09/18	0.00	2,221.00	0.00	0.00	0.00
615	2018131066681	04/16/18 - 04/16/18	05/21/18	0.00	2,221.00	0.00	0.00	0.00
-1	2018144098743	05/15/18 - 01/01/00	07/16/18	0.00	0.00	0.00	0.00	0.00
-1	2018144098743	05/15/18 - 01/01/00	07/16/18	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	8,884.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	231,670.49	ADJUSTMENTS	0.00
COVERED CHARGES	168,404.62	CONTRACTUAL ALLOW	88,558.90
NON-COVERD CHARGES	63,265.87	TOTAL MEDICAID LIAB	79,845.72
		LESS: COB	79,783.01
		LESS: COPAYMENT	62.71
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,737.61	0.00	OTHER LAB	324.00	0.00
MED/SURG SUPPLY	3,183.00	1,178.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,483.00	924.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,503.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,022.00	882.00
EKG/ECG	3,140.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,476.00	855.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,798.00	20,555.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,686.00	301.00	AMBULANCE	0.00	0.00
GI SERVICES	1,540.00	2,298.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,041.00	639.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,885.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,370.01	954.87
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	887.00	212.00	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	NO CC/INVALID REV CODE	0.00	3,410.00
OTHER IMAGING SERVICE	7,455.00	3,840.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,270.00	1,035.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,793.00	19,679.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,946.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	168,404.62	63,265.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,404.62	63,265.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
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	2018194063168	06/29/18 - 06/29/18	07/23/18	0.00	3,410.00	0.00	1,711.82	0.00
TOTAL				0.00	3,410.00	0.00	1,711.82	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	798,671.70	ADJUSTMENTS	161.82
COVERED CHARGES	770,905.68	CONTRACTUAL ALLOW	740,474.32
NON-COVERD CHARGES	27,766.02	TOTAL MEDICAID LIAB	30,431.36
		LESS: COB	0.00
		LESS: COPAYMENT	984.00
		REIMBURSEMENT	29,447.36
		TOTAL NUMBER OF CLAIMS	544

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,452.64	0.00	OTHER LAB	915.00	0.00
MED/SURG SUPPLY	3,557.90	2,511.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,501.00	3,847.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,719.00	5,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	271.00	FEE SCHEDULE LAB	65,753.00	3,167.00
EKG/ECG	12,180.00	580.00	MRI SERVICES	8,045.00	0.00
IV THERAPY	66,599.00	3,954.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,179.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,312.00	184.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,956.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	382,800.00	966.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,989.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,745.14	901.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	106.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,310.00	3,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,043.00	2,576.00			
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	2,849.00	0.00			

TOTAL ANCILLARY	770,905.68	27,766.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	770,905.68	27,766.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,482.82	ADJUSTMENTS	0.00
COVERED CHARGES	28,197.82	CONTRACTUAL ALLOW	18,209.71
NON-COVERD CHARGES	2,285.00	TOTAL MEDICAID LIAB	9,988.11
		LESS: COB	9,961.11
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.05	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	1,869.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,619.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,292.00	371.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,969.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,523.00	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	1,703.77	38.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,511.00	588.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	681.00	1,288.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,197.82	2,285.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,197.82	2,285.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,632,161.22	ADJUSTMENTS	65,153.84
COVERED CHARGES	2,110,031.80	CONTRACTUAL ALLOW	1,810,798.80
NON-COVERD CHARGES	522,129.42	TOTAL MEDICAID LIAB	299,233.00
		LESS: COB	0.00
		LESS: COPAYMENT	559.09
		REIMBURSEMENT	298,673.91

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,877.15	0.00	OTHER LAB	770.00	0.00
MED/SURG SUPPLY	77,287.85	35,783.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,506.00	17,416.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	613.00	FEE SCHEDULE LAB	20,649.00	3,497.00
EKG/ECG	4,060.00	580.00	MRI SERVICES	2,998.00	0.00
IV THERAPY	41,003.00	384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	765,005.25	29,903.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,505.00	5,880.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,050.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,818.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	630,121.55	15,857.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	479.00	495.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,589.00	380,720.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,998.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,626.00	2,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,678.00	364.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	129,675.00	25,062.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,546.00	0.00			

TOTAL ANCILLARY	2,110,031.80	522,129.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,110,031.80	522,129.42

GEORGIA 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 07/01/17 THROUGH 06/30/18
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	2018115070934	03/14/18 - 03/14/18	04/30/18	0.00	2,998.00	0.00	0.00	0.00
TOTAL				0.00	2,998.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,824,350.86	ADJUSTMENTS	6,267.97
COVERED CHARGES	1,772,025.96	CONTRACTUAL ALLOW	1,053,670.21
NON-COVERD CHARGES	52,324.90	TOTAL MEDICAID LIAB	718,355.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	718,355.75

TOTAL NUMBER OF ADMISSIONS 84

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	264	0	174,150.00	31,775.00
ROUTINE NURSERY	6	0	3,180.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	270	0	177,330.00	31,775.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	51	0	113,100.00	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	51	0	113,100.00	0.00
TOTAL ACCOMODATIONS	321	0	290,430.00	31,775.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192,795.16	0.00	OTHER LAB	3,024.30	0.00
MED/SURG SUPPLY	333,815.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	129,306.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,195.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,783.60	5,860.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,744.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,388.20	0.00	MRI SERVICES	6,855.50	0.00
IV THERAPY	146,017.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,856.80	630.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,538.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	228,216.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,556.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,080.05	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,617.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,022.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,017.85	0.00	INJECTABLE DRUGS	4,684.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	776.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	19,870.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,552.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,308.50	779.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,897.85	2,058.00			
AUDIOLOGY	218.85	0.00			
CARDIOLOGY	26,488.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,251.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,569.52	11,222.00			

TOTAL ANCILLARY	1,481,595.96	20,549.90
TOTAL ACCOMODATIONS	290,430.00	31,775.00
TOTAL CHARGES	1,772,025.96	52,324.90

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,277,769.41	ADJUSTMENTS	336,757.39
COVERED CHARGES	1,998,508.48	CONTRACTUAL ALLOW	1,229,055.56
NON-COVERD CHARGES	279,260.93	TOTAL MEDICAID LIAB	769,452.92
		LESS: COB	390.04
		LESS: COPAYMENT	1,856.25
		REIMBURSEMENT	767,206.63
		ALL OTHER	719,181.84
		FEE SCHEDULE-LAB	45,433.38
		INJECTABLE DRUGS	2,591.41
		TOTAL NUMBER OF CLAIMS	1,717

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,682.40	31,176.37	OTHER LAB	82,117.95	0.00
MED/SURG SUPPLY	155,951.38	99.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,942.35	5,024.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	247,296.05	46,664.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,117.45	3,829.55	FEE SCHEDULE LAB	220,379.25	11,011.18
EKG/ECG	18,023.85	1,589.30	MRI SERVICES	54,376.95	3,198.25
IV THERAPY	44,828.20	11,882.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,584.50	29,256.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	346.11	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,927.75	5,078.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,585.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,040.64	10,896.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	623,810.73	17,587.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,189.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,480.03	2,310.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,635.05	3,189.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,340.30	1,606.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,742.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,799.10	4,281.75			
BLOOD	494.60	0.00			
BLOOD STORAGE & PRO.	8,785.10	11,201.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,682.85	20,097.73			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,104.45	1,815.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,251.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,734.14	54,012.63			

TOTAL ANCILLARY	1,998,508.48	278,550.93
TOTAL ACCOMODATIONS	0.00	710.00
TOTAL CHARGES	1,998,508.48	279,260.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,154.96	ADJUSTMENTS	0.00
COVERED CHARGES	21,612.36	CONTRACTUAL ALLOW	4,780.43
NON-COVERD CHARGES	4,542.60	TOTAL MEDICAID LIAB	16,831.93
		LESS: COB	16,825.93
		LESS: COPAYMENT	6.00
		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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	832.51	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,511.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.85	240.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,377.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,915.78	363.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	374.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,341.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,687.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,606.60	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,707.15	915.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,552.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	961.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,606.60	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	359.00	0.00			

TOTAL ANCILLARY	21,612.36	4,542.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,612.36	4,542.60

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	200,867.93	ADJUSTMENTS	2,426.02
COVERED CHARGES	184,594.83	CONTRACTUAL ALLOW	169,748.23
NON-COVERD CHARGES	16,273.10	TOTAL MEDICAID LIAB	14,846.60
		LESS: COB	0.00
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	14,366.60

TOTAL NUMBER OF CLAIMS 253

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,647.05	1,828.96	OTHER LAB	1,104.15	0.00
MED/SURG SUPPLY	5,040.23	2.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,234.00	4,071.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,961.00	7,903.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	491.10	0.00	FEE SCHEDULE LAB	18,880.43	514.50
EKG/ECG	2,281.50	456.30	MRI SERVICES	0.00	0.00
IV THERAPY	3,504.70	300.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	381.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,256.75	637.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	934.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	558.05	558.05			
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	4,307.76	0.00			

TOTAL ANCILLARY	184,594.83	16,273.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	184,594.83	16,273.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,502.37	ADJUSTMENTS	0.00
COVERED CHARGES	5,549.22	CONTRACTUAL ALLOW	2,012.61
NON-COVERD CHARGES	1,953.15	TOTAL MEDICAID LIAB	3,536.61
		LESS: COB	3,530.61
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.18	74.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	828.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	217.05	1,857.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,336.54	20.90
EKG/ECG	228.15	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	2,862.00	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,549.22	1,953.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,549.22	1,953.15

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	389,480.77	ADJUSTMENTS	66,455.76
COVERED CHARGES	371,552.52	CONTRACTUAL ALLOW	277,283.61
NON-COVERD CHARGES	17,928.25	TOTAL MEDICAID LIAB	94,268.91
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	94,166.91
		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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,305.48	6,071.78	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110,479.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,041.60	1,557.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,291.95	1,857.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,035.10	206.00
EKG/ECG	0.00	228.15	MRI SERVICES	0.00	0.00
IV THERAPY	3,071.10	1,368.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,393.79	4,835.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,572.50	331.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,816.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,223.00	1,104.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,881.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	139.94	22.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,198.20	343.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,101.55	0.00			

TOTAL ANCILLARY	371,552.52	17,928.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	371,552.52	17,928.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,695,689.53	ADJUSTMENTS	131,840.28
COVERED CHARGES	21,666,573.07	CONTRACTUAL ALLOW	15,062,061.85
NON-COVERD CHARGES	29,116.46	TOTAL MEDICAID LIAB	6,604,511.22
		LESS: COB	42,902.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,561,608.86

TOTAL NUMBER OF ADMISSIONS 676

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,490	0	1,908,472.00	3,590.00
ROUTINE NURSERY	246	0	189,960.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,736	0	2,098,432.00	3,590.00
SPECIAL CARE SERVICES				
CCU	896	0	1,734,654.00	0.00
ICU	297	0	883,872.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,193	0	2,618,526.00	0.00
TOTAL ACCOMODATIONS	2,929	0	4,716,958.00	3,590.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,571,934.36	0.00	OTHER LAB	124,554.00	0.00
MED/SURG SUPPLY	1,009,519.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,649,450.78	0.00	EDUCATION & TRAINING	9,565.00	0.00
RADIOLOGY-DIAGNOSTIC	332,933.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	947,171.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	183,977.59	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	182,718.00	0.00	MRI SERVICES	192,462.00	0.00
IV THERAPY	399,351.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,316,388.00	1,960.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	310,178.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,080,510.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319,209.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	190,140.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	794,881.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	12,759.46
LABORATORY PATHOLOGIC	52,711.00	0.00	INJECTABLE DRUGS	1,172,739.31	0.00
RADIOLOGY THERAPEUTIC	17,663.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,285.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,111.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	61,096.00	9,660.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,237.00	237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,860.00	0.00	IMPL DEV CHARGE PATIENTS	1,024,211.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	206,155.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	204,368.00	0.00			
AUDIOLOGY	16,905.00	0.00			
CARDIOLOGY	1,184,136.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,635.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193,777.32	0.00			

TOTAL ANCILLARY	16,949,615.07	25,526.46
TOTAL ACCOMODATIONS	4,716,958.00	3,590.00
TOTAL CHARGES	21,666,573.07	29,116.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	679,837.57	ADJUSTMENTS	0.00
COVERED CHARGES	679,587.57	CONTRACTUAL ALLOW	211,914.76
NON-COVERD CHARGES	250.00	TOTAL MEDICAID LIAB	467,672.81
		LESS: COB	467,672.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	68	0	87,244.00	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	68	0	87,244.00	0.00
SPECIAL CARE SERVICES				
CCU	31	0	60,391.00	0.00
ICU	22	0	65,472.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	53	0	125,863.00	0.00
TOTAL ACCOMODATIONS	121	0	213,107.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,405.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,845.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	78,376.00	0.00	EDUCATION & TRAINING	455.00	0.00
RADIOLOGY-DIAGNOSTIC	8,922.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,962.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,505.33	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,152.00	0.00	MRI SERVICES	4,067.00	0.00
IV THERAPY	12,190.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,084.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,785.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112,388.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,960.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,570.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	440.00	0.00	INJECTABLE DRUGS	14,366.70	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	1,825.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,508.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,631.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,333.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,994.00	250.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,770.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,577.00	0.00			

TOTAL ANCILLARY	466,480.57	250.00
TOTAL ACCOMODATIONS	213,107.00	0.00
TOTAL CHARGES	679,587.57	250.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,708,102.75	ADJUSTMENTS	717,456.69
COVERED CHARGES	17,475,878.20	CONTRACTUAL ALLOW	14,175,501.93
NON-COVERD CHARGES	1,232,224.55	TOTAL MEDICAID LIAB	3,300,376.27
		LESS: COB	3,295.91
		LESS: COPAYMENT	8,403.00
		REIMBURSEMENT	3,288,677.36
		ALL OTHER	2,923,723.42
		FEE SCHEDULE-LAB	171,554.60
		INJECTABLE DRUGS	193,399.34

TOTAL NUMBER OF CLAIMS 5,968

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	547,679.17	148.56	OTHER LAB	138,472.75	1,612.00
MED/SURG SUPPLY	157,823.62	15,806.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,585.00
RADIOLOGY-DIAGNOSTIC	730,698.00	18,204.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,235,872.00	177,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,375.00	8,325.00	FEE SCHEDULE LAB	1,947,416.28	52,685.00
EKG/ECG	266,746.00	8,877.00	MRI SERVICES	628,103.00	50,218.00
IV THERAPY	1,235,324.00	123,579.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,057,493.49	50,488.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,509.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	230,123.00	9,090.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	235,894.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	334,351.00	8,167.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,102,835.52	31,858.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,020,432.37	208,371.00
RADIOLOGY THERAPEUTIC	320,390.00	1,785.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,015.00	1,630.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,817.00	2,740.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,728.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	340,181.56	37,276.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	434,000.00	0.00	IMPL DEV CHARGE PATIENTS	79,872.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,860.00
OTHER IMAGING SERVICE	483,823.00	90,224.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,480.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	309,835.00	61,893.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	589,255.00	115,273.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	246,882.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	698,508.00	143,297.64			

TOTAL ANCILLARY	17,475,878.20	1,232,224.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,475,878.20	1,232,224.55

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 07/01/17 THROUGH 06/30/18
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
905	5918255000602	05/17/18 - 05/17/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	05/21/18 - 05/21/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	05/23/18 - 05/23/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	06/01/18 - 06/01/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	06/04/18 - 06/04/18	09/17/18	0.00	372.00	0.00	0.00	0.00
TOTAL				0.00	1,860.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	336,803.22	ADJUSTMENTS	0.00
COVERED CHARGES	237,288.08	CONTRACTUAL ALLOW	54,865.33
NON-COVERD CHARGES	99,515.14	TOTAL MEDICAID LIAB	182,422.75
		LESS: COB	182,326.75
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,098.70	666.23	OTHER LAB	2,261.00	0.00
MED/SURG SUPPLY	939.60	1,544.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,526.00	2,822.00	OTHER THERAPEUTIC SVC	0.00	231.00
CT SCAN	9,260.00	32,588.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,876.00	2,166.00
EKG/ECG	4,035.00	0.00	MRI SERVICES	11,001.00	0.00
IV THERAPY	30,125.00	635.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,398.00	12,757.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	228.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,877.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,709.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,845.00	8,417.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,528.84	215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,221.94	1,279.03
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	497.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,976.00	3,720.00	IMPL DEV CHARGE PATIENTS	0.00	3,578.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14,136.00
OTHER IMAGING SERVICE	5,969.00	2,912.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,150.00	3,693.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,547.00	7,212.00			

TOTAL ANCILLARY	237,288.08	99,515.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	237,288.08	99,515.14

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 07/01/17 THROUGH 06/30/18
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
905	2018108028054	01/11/18 - 01/11/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/12/18 - 01/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/15/18 - 01/15/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/19/18 - 01/19/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/22/18 - 01/22/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/26/18 - 01/26/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/29/18 - 01/29/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/01/18 - 02/01/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/02/18 - 02/02/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/05/18 - 02/05/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/07/18 - 02/07/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/12/18 - 02/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/14/18 - 02/14/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/16/18 - 02/16/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/19/18 - 02/19/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/21/18 - 02/21/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/26/18 - 02/26/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/01/18 - 03/01/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/02/18 - 03/02/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/06/18 - 03/06/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/09/18 - 03/09/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/12/18 - 03/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/16/18 - 03/16/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018338074431	04/10/18 - 04/10/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/11/18 - 04/11/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/13/18 - 04/13/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/16/18 - 04/16/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/18/18 - 04/18/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/20/18 - 04/20/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/23/18 - 04/23/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/25/18 - 04/25/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/27/18 - 04/27/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/30/18 - 04/30/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/02/18 - 05/02/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/04/18 - 05/04/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/07/18 - 05/07/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/09/18 - 05/09/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/11/18 - 05/11/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
TOTAL				0.00	14,136.00	0.00	237,402.32	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	639,280.06	ADJUSTMENTS	1,238.62
COVERED CHARGES	626,392.87	CONTRACTUAL ALLOW	603,233.71
NON-COVERD CHARGES	12,887.19	TOTAL MEDICAID LIAB	23,159.16
		LESS: COB	0.00
		LESS: COPAYMENT	711.00
		REIMBURSEMENT	22,448.16
		TOTAL NUMBER OF CLAIMS	414

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,815.42	0.00	OTHER LAB	2,786.00	0.00
MED/SURG SUPPLY	1,494.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,435.00	288.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,003.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,125.00	2,411.00
EKG/ECG	8,339.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45,273.00	2,782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,400.00	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	297,560.64	981.24	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,843.19	479.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,836.00	1,096.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,482.00	299.00			

TOTAL ANCILLARY	626,392.87	12,887.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	626,392.87	12,887.19

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,489.48	ADJUSTMENTS	0.00
COVERED CHARGES	8,425.48	CONTRACTUAL ALLOW	3,932.23
NON-COVERD CHARGES	64.00	TOTAL MEDICAID LIAB	4,493.25
		LESS: COB	4,487.25
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	1,119.00	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	1,553.00	22.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	134.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	5,317.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	42.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,425.48	64.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,425.48	64.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,812,101.92	ADJUSTMENTS	196,453.08
COVERED CHARGES	5,500,552.83	CONTRACTUAL ALLOW	4,719,879.68
NON-COVERD CHARGES	311,549.09	TOTAL MEDICAID LIAB	780,673.15
		LESS: COB	0.00
		LESS: COPAYMENT	934.74
		REIMBURSEMENT	779,738.41

TOTAL NUMBER OF CLAIMS 135

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145,665.39	0.00	OTHER LAB	5,321.00	2,396.00
MED/SURG SUPPLY	205,180.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	480.00
RADIOLOGY-DIAGNOSTIC	28,613.00	10,721.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,106.00	18,866.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,535.00	6,745.00	FEE SCHEDULE LAB	116,200.00	4,417.00
EKG/ECG	22,085.00	2,179.00	MRI SERVICES	12,691.00	3,584.00
IV THERAPY	268,862.00	44,627.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	659,445.72	15,706.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,354.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,528.00	2,889.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,021.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,187,880.41	13,614.81
RADIOLOGY THERAPEUTIC	583,338.00	4,945.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,500.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	361.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	529,418.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,375.00	6,206.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,570.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	385,506.00	94,652.00			
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	166,165.00	68,090.00			

TOTAL ANCILLARY	5,500,552.83	311,549.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,500,552.83	311,549.09

GEORGIA DEPARTMENT OF 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,545.78	ADJUSTMENTS	0.00
COVERED CHARGES	46,620.53	CONTRACTUAL ALLOW	-991.40
NON-COVERD CHARGES	40,925.25	TOTAL MEDICAID LIAB	47,611.93
		LESS: COB	47,605.93
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,320.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,484.32	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	1,276.00	275.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	1,054.25	63.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	25,307.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,216.00	14,108.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,032.00			

TOTAL ANCILLARY	46,620.53	40,925.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,620.53	40,925.25

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,049,191.43	ADJUSTMENTS	0.00
COVERED CHARGES	4,891,711.27	CONTRACTUAL ALLOW	4,497,203.62
NON-COVERD CHARGES	157,480.16	TOTAL MEDICAID LIAB	394,507.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	394,507.65

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	62,690.00	155,646.72
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	72	0	62,690.00	155,646.72
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	72	0	62,690.00	155,646.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,289.72	0.00	OTHER LAB	9,080.52	0.00
MED/SURG SUPPLY	18,091.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,410.84	0.00	EDUCATION & TRAINING	620.36	0.00
RADIOLOGY-DIAGNOSTIC	4,057.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,355.61	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,563.89	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,241.85	0.00	MRI SERVICES	7,934.92	0.00
IV THERAPY	2,756.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,949,487.88	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,996.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,166.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	78.64	0.00	INJECTABLE DRUGS	30.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,372.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,619,390.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,440.74
OTHER IMAGING SERVICE	788.94	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,515.12	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	5,292.20	0.00			

TOTAL ANCILLARY	4,829,021.27	1,833.44
TOTAL ACCOMODATIONS	62,690.00	155,646.72
TOTAL CHARGES	4,891,711.27	157,480.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
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
41	2218213000686	07/08/18 - 07/09/18	08/06/18	0.00	1,440.74	0.00	0.00	0.00
TOTAL				0.00	1,440.74	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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	481,262.78	ADJUSTMENTS	0.00
COVERED CHARGES	474,980.78	CONTRACTUAL ALLOW	225,733.34
NON-COVERD CHARGES	6,282.00	TOTAL MEDICAID LIAB	249,247.44
		LESS: COB	249,247.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	2,718.00	6,282.00
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	2,718.00	6,282.00
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	2,718.00	6,282.00

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 TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,602.31	0.00	OTHER LAB	1,300.00	0.00
MED/SURG SUPPLY	1,125.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	405.12	0.00	EDUCATION & TRAINING	47.72	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	1,147.49	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	236,432.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	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	151.96	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	222,489.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	472,262.78	0.00
TOTAL ACCOMODATIONS	2,718.00	6,282.00
TOTAL CHARGES	474,980.78	6,282.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,873,682.68	ADJUSTMENTS	137,377.13
COVERED CHARGES	4,500,293.24	CONTRACTUAL ALLOW	3,986,081.83
NON-COVERD CHARGES	373,389.44	TOTAL MEDICAID LIAB	514,211.41
		LESS: COB	7,965.36
		LESS: COPAYMENT	2,046.00
		REIMBURSEMENT	504,200.05
		ALL OTHER	453,516.34
		FEE SCHEDULE-LAB	50,449.57
		INJECTABLE DRUGS	234.14

TOTAL NUMBER OF CLAIMS 1,715

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,058.49	15.11	OTHER LAB	54,373.23	2,280.52
MED/SURG SUPPLY	6,678.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	238.60
RADIOLOGY-DIAGNOSTIC	96,661.38	1,385.78	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	227,086.23	23,162.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,494.97	12,253.85	FEE SCHEDULE LAB	440,864.66	22,056.60
EKG/ECG	29,316.50	689.80	MRI SERVICES	198,608.97	1,806.56
IV THERAPY	46,153.60	6,438.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,924,151.04	275,741.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,996.02	2,028.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	5,000.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	252,230.48	1,459.70	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	2,036.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,627.67	7,032.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	31,553.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,520.00	606.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,368.00	1,178.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,096.88	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,417.26	10,014.36			

TOTAL ANCILLARY	4,500,293.24	373,389.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,500,293.24	373,389.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,878.27	ADJUSTMENTS	0.00
COVERED CHARGES	32,026.26	CONTRACTUAL ALLOW	23,138.83
NON-COVERD CHARGES	1,852.01	TOTAL MEDICAID LIAB	8,887.43
		LESS: COB	8,863.43
		LESS: COPAYMENT	24.00
		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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,552.14	0.00	OTHER LAB	2,045.51	500.00
MED/SURG SUPPLY	42.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	826.02	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,073.24	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	883.42	997.72	FEE SCHEDULE LAB	5,509.62	181.84
EKG/ECG	862.25	172.45	MRI SERVICES	3,894.66	0.00
IV THERAPY	811.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,134.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	440.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	950.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,026.26	1,852.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,026.26	1,852.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,656.82	ADJUSTMENTS	4,642.00
COVERED CHARGES	147,448.78	CONTRACTUAL ALLOW	136,138.78
NON-COVERD CHARGES	4,208.04	TOTAL MEDICAID LIAB	11,310.00
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	10,941.00
		TOTAL NUMBER OF CLAIMS	193

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,628.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	838.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	95.44
RADIOLOGY-DIAGNOSTIC	10,041.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,854.55	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,931.52	1,567.92
EKG/ECG	1,207.15	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	7,838.48	1,548.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,234.44	392.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,177.47	0.00	SPECIAL SERVICES	0.00	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	6.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	425.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	697.14	0.00			

TOTAL ANCILLARY	147,448.78	4,208.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,448.78	4,208.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	522.11	ADJUSTMENTS	0.00
COVERED CHARGES	498.11	CONTRACTUAL ALLOW	298.86
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	199.25
		LESS: COB	199.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	178.56	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	498.11	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	498.11	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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,331,305.63	ADJUSTMENTS	9,708.40
COVERED CHARGES	1,287,982.40	CONTRACTUAL ALLOW	1,201,347.22
NON-COVERD CHARGES	43,323.23	TOTAL MEDICAID LIAB	86,635.18
		LESS: COB	13,190.12
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	73,382.06

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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,287.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,080.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	374.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,745.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,657.18	FEE SCHEDULE LAB	1,439.76	120.00
EKG/ECG	172.45	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,045,184.88	38,873.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,500.00	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	13,720.42	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	189,879.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	765.00	0.00			

TOTAL ANCILLARY	1,287,982.40	43,323.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,287,982.40	43,323.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,146,523.07	ADJUSTMENTS	492,661.50
COVERED CHARGES	30,591,605.56	CONTRACTUAL ALLOW	23,661,903.93
NON-COVERD CHARGES	554,917.51	TOTAL MEDICAID LIAB	6,929,701.63
		LESS: COB	75,763.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,853,938.50

TOTAL NUMBER OF ADMISSIONS 743

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,934	0	2,737,900.10	206,860.00
ROUTINE NURSERY	221	0	178,580.00	45,430.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.01
TOTAL ROUTINE	3,155	0	2,916,480.10	252,290.01
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,003	0	2,167,880.00	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	1,003	0	2,167,880.00	0.00
TOTAL ACCOMODATIONS	4,158	0	5,084,360.10	252,290.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,246,781.88	0.00	OTHER LAB	100,212.07	0.00
MED/SURG SUPPLY	1,575,740.24	9,910.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,590,934.42	0.00	EDUCATION & TRAINING	542.01	0.00
RADIOLOGY-DIAGNOSTIC	569,676.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,479,889.73	40,264.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	261,449.97	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	181,414.23	0.00	MRI SERVICES	222,268.52	0.00
IV THERAPY	78,423.38	0.00	PROFESSIONAL FEES	0.00	22,016.65
OPERATING ROOM	1,122,041.01	1,206.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	181,117.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	978,603.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	230,170.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	127,798.24	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,972,121.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	142,965.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	88,297.07	0.00	INJECTABLE DRUGS	5,031,993.50	0.00
RADIOLOGY THERAPEUTIC	488.89	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,118.66	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,350.98	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	165,861.40	733.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,056.53	1,558.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	799,903.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	122,085.24	22,257.81			
BLOOD	78,442.26	0.00			
BLOOD STORAGE & PRO.	377,353.24	130,737.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,083.46	36,398.55			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	895,609.61	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,565.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	629,886.19	37,543.50			

TOTAL ANCILLARY	25,507,245.46	302,627.50
TOTAL ACCOMODATIONS	5,084,360.10	252,290.01
TOTAL CHARGES	30,591,605.56	554,917.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	154,493.97	ADJUSTMENTS	0.00
COVERED CHARGES	135,374.57	CONTRACTUAL ALLOW	35,938.79
NON-COVERD CHARGES	19,119.40	TOTAL MEDICAID LIAB	99,435.78
		LESS: COB	99,435.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15	0	14,100.00	1,570.00
ROUTINE NURSERY	17	0	15,620.00	11,550.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	32	0	29,720.00	13,120.00
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	32	0	29,720.00	13,120.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,464.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,841.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,306.78	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,630.11	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	498.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	136.59	0.00	PROFESSIONAL FEES	0.00	5,999.40
OPERATING ROOM	19,100.08	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,000.66	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,142.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,198.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,141.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,966.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	539.75	0.00	INJECTABLE DRUGS	10,160.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	311.92	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	902.89	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,242.63	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,725.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,580.84	0.00			

TOTAL ANCILLARY	105,654.57	5,999.40
TOTAL ACCOMODATIONS	29,720.00	13,120.00
TOTAL CHARGES	135,374.57	19,119.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,840,677.02	ADJUSTMENTS	1,280,365.75
COVERED CHARGES	25,149,876.19	CONTRACTUAL ALLOW	21,614,481.57
NON-COVERD CHARGES	3,690,800.83	TOTAL MEDICAID LIAB	3,535,394.62
		LESS: COB	10,866.77
		LESS: COPAYMENT	12,426.93
		REIMBURSEMENT	3,512,100.92
		ALL OTHER	2,750,882.48
		FEE SCHEDULE-LAB	486,725.15
		INJECTABLE DRUGS	274,493.29

TOTAL NUMBER OF CLAIMS 9,642

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,477,279.46	83,754.60	OTHER LAB	852,139.77	1,382.92
MED/SURG SUPPLY	570,333.70	30,525.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	93.50	EDUCATION & TRAINING	0.00	97.00
RADIOLOGY-DIAGNOSTIC	1,015,786.36	45,082.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,079,113.50	487,206.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,543.32	23,837.80	FEE SCHEDULE LAB	5,481,199.90	311,852.93
EKG/ECG	225,069.80	14,447.22	MRI SERVICES	569,770.46	46,980.39
IV THERAPY	418,147.09	76,318.13	PROFESSIONAL FEES	0.00	16,318.74
OPERATING ROOM	1,478,191.18	353,334.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	162.00
RESPIRATORY SERVICES	128,348.43	30,198.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	316,734.31	3,287.45	AMBULANCE	0.00	0.00
GI SERVICES	479,335.63	48,439.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343,611.08	138,212.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	296,457.79	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,858,201.52	947,771.61
RADIOLOGY THERAPEUTIC	639,079.52	197,533.10	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,418.38	7,227.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,386.88	5,264.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,145.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	106,148.12	31,922.01	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	85,894.75	345,478.35
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	274.00	7,499.52
OTHER IMAGING SERVICE	681,228.69	55,606.73			
BLOOD	20,415.01	0.00			
BLOOD STORAGE & PRO.	135,447.58	18,514.43			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	401,569.75	107,264.49			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	600,873.62	176,340.43			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,371.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	787,504.97	62,700.99			

TOTAL ANCILLARY	25,149,876.19	3,690,800.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,149,876.19	3,690,800.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2017319001130	11/08/17 - 11/08/17	11/20/17	34.25	0.00	0.00	0.00	20.52
948	2017342065352	11/07/17 - 11/07/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/09/17 - 11/09/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/14/17 - 11/14/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/16/17 - 11/16/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/21/17 - 11/21/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/28/17 - 11/28/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/30/17 - 11/30/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017361003396	11/27/17 - 11/27/17	01/01/18	0.00	277.76	0.00	0.00	0.00
948	2017361003396	11/29/17 - 11/29/17	01/01/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/07/17 - 12/07/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/12/17 - 12/12/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/14/17 - 12/14/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009005931	12/06/17 - 12/06/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009005931	12/13/17 - 12/13/17	01/15/18	0.00	277.76	0.00	0.00	0.00
780	2018074078512	03/07/18 - 03/07/18	03/19/18	34.25	0.00	0.00	0.00	20.52
780	2018088092806	03/21/18 - 03/21/18	04/02/18	34.25	0.00	0.00	0.00	20.52
780	2018103073317	04/04/18 - 04/04/18	04/23/18	34.25	0.00	0.00	0.00	20.52
948	2018127032757	04/09/18 - 04/09/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127032757	04/11/18 - 04/11/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/16/18 - 04/16/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/18/18 - 04/18/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/23/18 - 04/23/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/25/18 - 04/25/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/30/18 - 04/30/18	05/14/18	0.00	277.76	0.00	0.00	0.00
780	2018128076604	04/30/18 - 04/30/18	05/14/18	34.25	0.00	0.00	0.00	20.52
948	2018163017862	05/07/18 - 05/07/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/09/18 - 05/09/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/16/18 - 05/16/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/23/18 - 05/23/18	06/18/18	0.00	277.76	0.00	0.00	0.00
780	2018179084180	05/23/18 - 05/23/18	07/02/18	34.25	0.00	0.00	0.00	20.52
780	2018219066523	07/18/18 - 07/18/18	08/13/18	34.25	0.00	0.00	0.00	20.52
780	2018251023360	08/23/18 - 08/23/18	09/17/18	34.25	0.00	0.00	0.00	20.52
948	2018289073777	08/15/18 - 08/15/18	10/22/18	0.00	277.76	0.00	0.00	0.00
948	2018289073779	08/29/18 - 08/29/18	10/22/18	0.00	277.76	0.00	0.00	0.00
TOTAL				274.00	7,499.52	0.00	0.00	164.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	547,912.21	ADJUSTMENTS	0.00
COVERED CHARGES	367,661.52	CONTRACTUAL ALLOW	36,599.76
NON-COVERD CHARGES	180,250.69	TOTAL MEDICAID LIAB	331,061.76
		LESS: COB	330,887.34
		LESS: COPAYMENT	174.42
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 157

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,209.49	3,351.23	OTHER LAB	9,048.07	222.22
MED/SURG SUPPLY	7,246.08	19.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,061.85	1,337.03	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,774.12	58,678.96	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	447.37	4,699.89	FEE SCHEDULE LAB	107,466.68	11,677.25
EKG/ECG	2,739.99	314.25	MRI SERVICES	0.00	7,466.40
IV THERAPY	11,920.23	1,969.75	PROFESSIONAL FEES	0.00	38,913.23
OPERATING ROOM	20,178.55	13,371.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	116.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,922.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,298.38	1,588.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,235.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,187.36	8,871.59
RADIOLOGY THERAPEUTIC	33,275.45	5,856.17	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,404.00	322.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,234.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,280.53	8,150.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,659.01	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,835.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,706.80	5,858.42			
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	16,483.19	2,512.48			

TOTAL ANCILLARY	367,661.52	180,250.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	367,661.52	180,250.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	540,801.64	ADJUSTMENTS	7,964.49
COVERED CHARGES	493,453.91	CONTRACTUAL ALLOW	467,983.07
NON-COVERD CHARGES	47,347.73	TOTAL MEDICAID LIAB	25,470.84
		LESS: COB	31.53
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	24,635.31
		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

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,335.20	1,991.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,076.46	2,567.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,015.96	9,040.17	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,323.47	11,925.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	104,734.31	6,034.53
EKG/ECG	4,732.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,573.82	70.48	PROFESSIONAL FEES	0.00	3,950.68
OPERATING ROOM	7,293.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,062.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	215,912.99	3,461.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	683.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,830.55	6,522.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	43.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,229.53	1,739.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	176.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,822.64	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,725.80	0.00			

TOTAL ANCILLARY	493,453.91	47,347.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	493,453.91	47,347.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,714.73	ADJUSTMENTS	0.00
COVERED CHARGES	16,561.21	CONTRACTUAL ALLOW	-1,525.28
NON-COVERD CHARGES	15,153.52	TOTAL MEDICAID LIAB	18,086.49
		LESS: COB	18,077.49
		LESS: COPAYMENT	9.00
		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

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	677.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	189.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.43	312.56	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,746.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,492.28	36.77
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	770.02	0.00	PROFESSIONAL FEES	0.00	4,761.80
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,010.79	271.24	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.48	1,024.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	88.44	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	0.00	0.00			

TOTAL ANCILLARY	16,561.21	15,153.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,561.21	15,153.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,784,615.39	ADJUSTMENTS	184,791.40
COVERED CHARGES	3,499,196.68	CONTRACTUAL ALLOW	3,107,473.48
NON-COVERD CHARGES	285,418.71	TOTAL MEDICAID LIAB	391,723.20
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	391,363.20

TOTAL NUMBER OF CLAIMS 72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,562.91	2,430.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82,399.98	262.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.20	EDUCATION & TRAINING	0.00	97.00
RADIOLOGY-DIAGNOSTIC	2,816.69	6,813.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,277.91	6,925.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,672.15	FEE SCHEDULE LAB	40,819.38	4,799.73
EKG/ECG	996.36	1,802.70	MRI SERVICES	40,009.12	2,913.44
IV THERAPY	12,943.26	578.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	247,341.74	41,013.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,722.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,151.55	1,972.47	AMBULANCE	0.00	0.00
GI SERVICES	13,639.28	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,038.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,245.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,360,958.59	174,801.14
RADIOLOGY THERAPEUTIC	149,391.71	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	637.49	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,089.43	1,022.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,074.47	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,007.04	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,830.45	37,154.66			
AMBULATORY SURGERY	4,629.39	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,250.72	459.14			

TOTAL ANCILLARY	3,499,196.68	285,418.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,499,196.68	285,418.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,148,044.13	ADJUSTMENTS	76,471.17
COVERED CHARGES	1,102,345.13	CONTRACTUAL ALLOW	641,780.38
NON-COVERD CHARGES	45,699.00	TOTAL MEDICAID LIAB	460,564.75
		LESS: COB	30,656.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	429,908.27

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	174	0	130,500.00	25,235.00
ROUTINE NURSERY	24	0	15,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	198	0	145,700.00	25,235.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	12	0	15,600.00	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	12	0	15,600.00	0.00
TOTAL ACCOMODATIONS	210	0	161,300.00	25,235.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124,565.00	0.00	OTHER LAB	2,609.00	0.00
MED/SURG SUPPLY	19,911.00	141.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,057.00	0.00	EDUCATION & TRAINING	243.00	0.00
RADIOLOGY-DIAGNOSTIC	35,517.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,740.00
CT SCAN	22,320.00	9,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,385.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,435.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,340.00	0.00	PROFESSIONAL FEES	0.00	853.00
OPERATING ROOM	69,583.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,786.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,434.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,450.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,300.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,995.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,430.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	839.50	120.00	INJECTABLE DRUGS	81,470.00	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	642.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,397.00	3,710.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,093.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,390.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,895.00	3,780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,280.00	0.00			
AUDIOLOGY	3,430.00	0.00			
CARDIOLOGY	17,676.20	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	21,571.47	0.00			

TOTAL ANCILLARY	941,045.13	20,464.00
TOTAL ACCOMODATIONS	161,300.00	25,235.00
TOTAL CHARGES	1,102,345.13	45,699.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,190.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,090.00	CONTRACTUAL ALLOW	-155.37
NON-COVERD CHARGES	100.00	TOTAL MEDICAID LIAB	2,245.37
		LESS: COB	2,245.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,500.00	100.00
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	1,500.00	100.00
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	1,500.00	100.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	590.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	590.00	0.00
TOTAL ACCOMODATIONS	1,500.00	100.00
TOTAL CHARGES	2,090.00	100.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,375,783.03	ADJUSTMENTS	89,838.65
COVERED CHARGES	2,294,674.31	CONTRACTUAL ALLOW	1,792,861.71
NON-COVERD CHARGES	81,108.72	TOTAL MEDICAID LIAB	501,812.60
		LESS: COB	136.24
		LESS: COPAYMENT	1,453.60
		REIMBURSEMENT	500,222.76
		ALL OTHER	431,612.32
		FEE SCHEDULE-LAB	52,708.58
		INJECTABLE DRUGS	15,901.86

TOTAL NUMBER OF CLAIMS 1,471

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,247.00	180.00	OTHER LAB	44,754.00	0.00
MED/SURG SUPPLY	10,513.00	251.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,409.00	3,483.00	OTHER THERAPEUTIC SVC	0.00	1,650.00
CT SCAN	395,880.00	2,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,605.00	860.00	FEE SCHEDULE LAB	325,100.10	12,976.00
EKG/ECG	5,106.00	205.00	MRI SERVICES	44,970.00	0.00
IV THERAPY	42,300.00	7,710.00	PROFESSIONAL FEES	0.00	148.00
OPERATING ROOM	269,198.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,100.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,547.00	1,719.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,370.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,100.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	508,902.64	24,635.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	117,721.26	9,862.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	456.00	55.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	578.00	191.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,775.00	4,778.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,365.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,670.40	3,172.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,698.00	2,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,950.00	2,181.60			
AUDIOLOGY	245.00	0.00			
CARDIOLOGY	19,921.40	1,500.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,322.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,070.51	1,020.00			

TOTAL ANCILLARY	2,294,674.31	81,108.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,294,674.31	81,108.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,676.91	ADJUSTMENTS	0.00
COVERED CHARGES	51,316.91	CONTRACTUAL ALLOW	8,062.73
NON-COVERD CHARGES	16,360.00	TOTAL MEDICAID LIAB	43,254.18
		LESS: COB	43,243.88
		LESS: COPAYMENT	10.30
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,518.00	0.00	OTHER LAB	250.00	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	2,715.00	0.00	OTHER THERAPEUTIC SVC	0.00	450.00
CT SCAN	3,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,059.90	188.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,040.00	2,370.00
IV THERAPY	1,140.00	0.00	PROFESSIONAL FEES	0.00	1,080.00
OPERATING ROOM	4,727.00	9,854.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,895.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,249.41	540.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	939.00	130.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,153.60	540.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,380.00	108.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100.00	0.00			

TOTAL ANCILLARY	51,316.91	16,360.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,316.91	16,360.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	95,007.95	ADJUSTMENTS	211.76
COVERED CHARGES	93,615.95	CONTRACTUAL ALLOW	87,686.31
NON-COVERD CHARGES	1,392.00	TOTAL MEDICAID LIAB	5,929.64
		LESS: COB	44.47
		LESS: COPAYMENT	217.20
		REIMBURSEMENT	5,667.97
		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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,440.00	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	6,510.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,660.00	828.00
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	50,369.95	480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,176.00	84.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	900.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,615.95	1,392.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,615.95	1,392.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,359.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,343.08	CONTRACTUAL ALLOW	1,726.09
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	616.99
		LESS: COB	616.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.00	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	867.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,386.08	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,343.08	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,343.08	16.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	211,608.12	ADJUSTMENTS	5,434.60
COVERED CHARGES	211,057.12	CONTRACTUAL ALLOW	178,413.52
NON-COVERD CHARGES	551.00	TOTAL MEDICAID LIAB	32,643.60
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	32,544.60

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,810.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	20.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105.00	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	748.00	16.00
EKG/ECG	205.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,680.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,788.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	450.00	450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,375.00	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	1,175.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	163,921.12	65.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,800.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	211,057.12	551.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,057.12	551.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,548,838.82	ADJUSTMENTS	781,992.31
COVERED CHARGES	52,207,136.03	CONTRACTUAL ALLOW	36,449,758.69
NON-COVERD CHARGES	341,702.79	TOTAL MEDICAID LIAB	15,757,377.34
		LESS: COB	224,152.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,533,225.23

TOTAL NUMBER OF ADMISSIONS 1,450

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,358	0	1,947,640.00	300.00
ROUTINE NURSERY	476	0	410,799.00	1,453.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,834	0	2,358,439.00	1,753.00
SPECIAL CARE SERVICES				
CCU	160	0	260,000.00	0.00
ICU	4,790	0	5,065,744.00	0.00
NICU	312	0	509,262.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,262	0	5,835,006.00	0.00
TOTAL ACCOMODATIONS	9,096	0	8,193,445.00	1,753.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,776,354.04	827.42	OTHER LAB	365,177.00	0.00
MED/SURG SUPPLY	7,459,945.65	195,361.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,757,523.68	0.00	EDUCATION & TRAINING	28,898.00	0.00
RADIOLOGY-DIAGNOSTIC	1,119,660.00	0.00	OTHER THERAPEUTIC SVC	69,429.00	20,671.00
CT SCAN	2,595,373.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	291,387.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	341,619.00	0.00	MRI SERVICES	593,285.00	0.00
IV THERAPY	308,262.00	814.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,107,857.00	8,153.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	96,800.00	0.00	REHAB THERAPY	3,540.00	0.00
RESPIRATORY SERVICES	3,083,474.00	624.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	234,436.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	279,928.00	2,801.00	CAST ROOM	460.00	0.00
EMERGENCY ROOM	1,156,825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,612.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	174,287.45	0.00	INJECTABLE DRUGS	7,015.92	0.00
RADIOLOGY THERAPEUTIC	23,688.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	135,599.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	74,338.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	366,120.00	20,250.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,044.00	3,560.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,928,106.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	15,678.00
OTHER IMAGING SERVICE	224,498.00	4,900.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	565,845.00	7,784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	229,373.00	57,312.00			
AUDIOLOGY	18,902.00	0.00			
CARDIOLOGY	1,873,068.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,775.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	452,186.00	1,214.00			

TOTAL ANCILLARY	44,013,691.03	339,949.79
TOTAL ACCOMODATIONS	8,193,445.00	1,753.00
TOTAL CHARGES	52,207,136.03	341,702.79

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 01/01/18 THROUGH 12/31/18
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	2018158014678	05/24/18 - 05/31/18	06/11/18	0.00	2,613.00	0.00	0.00	0.00
615	2018158014723	05/25/18 - 05/31/18	06/11/18	0.00	2,613.00	0.00	0.00	0.00
615	2018250033293	08/22/18 - 08/29/18	09/10/18	0.00	2,613.00	0.00	0.00	0.00
615	2018345028726	05/22/18 - 06/04/18	12/17/18	0.00	2,613.00	0.00	0.00	0.00
615	2019065033743	10/05/18 - 10/07/18	03/11/19	0.00	2,613.00	0.00	0.00	0.00
615	2019178043029	09/17/18 - 09/17/18	07/01/19	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	15,678.00	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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	370,399.28	ADJUSTMENTS	0.00
COVERED CHARGES	370,399.28	CONTRACTUAL ALLOW	173,730.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	196,668.41
		LESS: COB	196,668.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	22,620.00	0.00
ROUTINE NURSERY	21	0	18,345.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	40,965.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	9,959.00	0.00
NICU	1	0	1,625.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	11,584.00	0.00
TOTAL ACCOMODATIONS	70	0	52,549.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,947.11	0.00	OTHER LAB	2,034.00	0.00
MED/SURG SUPPLY	71,802.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,251.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,693.00	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	4,454.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,483.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,538.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,097.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,251.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,186.06	0.00	INJECTABLE DRUGS	9.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	756.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,800.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,685.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	954.00	0.00			
CARDIOLOGY	57,074.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,707.00	0.00			

TOTAL ANCILLARY	317,850.28	0.00
TOTAL ACCOMODATIONS	52,549.00	0.00
TOTAL CHARGES	370,399.28	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,254,936.21	ADJUSTMENTS	1,046,120.85
COVERED CHARGES	20,609,470.41	CONTRACTUAL ALLOW	16,635,702.90
NON-COVERD CHARGES	1,645,465.80	TOTAL MEDICAID LIAB	3,973,767.51
		LESS: COB	39,329.51
		LESS: COPAYMENT	14,617.30
		REIMBURSEMENT	3,919,820.70
		ALL OTHER	3,109,743.13
		FEE SCHEDULE-LAB	416,257.84
		INJECTABLE DRUGS	393,819.73

TOTAL NUMBER OF CLAIMS 12,250

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	929,130.70	5,434.67	OTHER LAB	581,467.00	133.00
MED/SURG SUPPLY	2,091,466.48	30,825.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	38.00	EDUCATION & TRAINING	99.00	2,798.00
RADIOLOGY-DIAGNOSTIC	948,006.00	34,814.00	OTHER THERAPEUTIC SVC	896.00	602.00
CT SCAN	2,501,162.00	363,321.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,176.00	9,527.00	FEE SCHEDULE LAB	2,692,918.26	113,443.78
EKG/ECG	357,363.00	2,768.00	MRI SERVICES	637,858.00	45,788.00
IV THERAPY	1,079,943.00	61,722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,410,660.96	269,707.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,346.00	0.00	REHAB THERAPY	0.00	90.00
RESPIRATORY SERVICES	98,542.00	8,139.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	91,778.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	163,796.50	31,103.50	CAST ROOM	18,026.00	1,380.00
EMERGENCY ROOM	2,926,327.00	4,296.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	139,971.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,507,787.05	327,539.78
RADIOLOGY THERAPEUTIC	14,982.00	567.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,529.00	6,845.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,442.00	4,209.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,720.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	269,731.00	73,120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	97,331.98	13,021.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,813.00
OTHER IMAGING SERVICE	543,644.00	43,231.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,502.48	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	387,110.00	48,565.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	668,023.00	123,658.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,576.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296,879.00	1,659.00			

TOTAL ANCILLARY	20,609,470.41	1,645,465.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,609,470.41	1,645,465.80

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 01/01/18 THROUGH 12/31/18
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	2018197023737	06/20/18 - 06/20/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023738	06/21/18 - 06/21/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023739	06/25/18 - 06/25/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023740	07/02/18 - 07/02/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023742	07/09/18 - 07/09/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023744	07/11/18 - 07/11/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018226031853	07/12/18 - 07/12/18	08/20/18	0.00	525.00	0.00	0.00	0.00
948	2018226031854	07/16/18 - 07/16/18	08/20/18	0.00	525.00	0.00	0.00	0.00
615	2019162024905	12/10/18 - 12/10/18	06/17/19	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	6,813.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,159.17	ADJUSTMENTS	0.00
COVERED CHARGES	211,446.45	CONTRACTUAL ALLOW	125,527.57
NON-COVERD CHARGES	40,712.72	TOTAL MEDICAID LIAB	85,918.88
		LESS: COB	85,816.88
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,159.83	0.00	OTHER LAB	1,877.00	0.00
MED/SURG SUPPLY	28,545.46	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,774.00	599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,050.00	17,520.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.00	FEE SCHEDULE LAB	26,507.92	1,824.57
EKG/ECG	1,572.00	0.00	MRI SERVICES	13,277.00	0.00
IV THERAPY	17,535.00	945.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,226.00	4,705.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,215.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	450.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,347.00	825.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,261.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,501.24	5,685.15
RADIOLOGY THERAPEUTIC	591.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,164.00	177.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,806.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,306.00	5,792.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,393.00	2,088.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	888.00	137.00			

TOTAL ANCILLARY	211,446.45	40,712.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,446.45	40,712.72

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	352,134.43	ADJUSTMENTS	6,800.14
COVERED CHARGES	341,815.38	CONTRACTUAL ALLOW	314,279.57
NON-COVERD CHARGES	10,319.05	TOTAL MEDICAID LIAB	27,535.81
		LESS: COB	147.20
		LESS: COPAYMENT	756.00
		REIMBURSEMENT	26,632.61

TOTAL NUMBER OF CLAIMS 451

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,141.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,623.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,896.00	1,936.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,472.00	3,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	588.00	FEE SCHEDULE LAB	67,175.56	1,530.14
EKG/ECG	5,764.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,092.00	189.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,783.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	214.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	174,898.00	986.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	920.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,389.32	167.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,446.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	341,815.38	10,319.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	341,815.38	10,319.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,666.59	ADJUSTMENTS	0.00
COVERED CHARGES	15,870.59	CONTRACTUAL ALLOW	11,729.07
NON-COVERD CHARGES	3,796.00	TOTAL MEDICAID LIAB	4,141.52
		LESS: COB	4,126.52
		LESS: COPAYMENT	15.00
		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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	994.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	485.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,136.00	3,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,783.04	60.00
EKG/ECG	524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,094.00	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	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	5,168.00	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	761.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,870.59	3,796.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,870.59	3,796.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,275,224.50	ADJUSTMENTS	255,925.89
COVERED CHARGES	3,318,966.32	CONTRACTUAL ALLOW	2,586,046.94
NON-COVERD CHARGES	956,258.18	TOTAL MEDICAID LIAB	732,919.38
		LESS: COB	4,959.06
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	727,480.32

TOTAL NUMBER OF CLAIMS 134

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,583.18	0.00	OTHER LAB	175.00	0.00
MED/SURG SUPPLY	603,600.77	231,318.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	98.00	0.00
RADIOLOGY-DIAGNOSTIC	77,791.00	35,101.00	OTHER THERAPEUTIC SVC	0.00	71.00
CT SCAN	3,736.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	675.00	FEE SCHEDULE LAB	31,043.46	450.00
EKG/ECG	3,668.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	53,586.00	2,079.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	643,084.66	551,894.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	495.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,552.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,125,487.31	50,373.66
RADIOLOGY THERAPEUTIC	1,323.00	567.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	810.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	488,753.94	25,425.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,599.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,256.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,730.00	480.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	191,160.00	56,824.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,754.00	0.00			

TOTAL ANCILLARY	3,318,966.32	956,258.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,318,966.32	956,258.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,998,148.94	ADJUSTMENTS	100,075.12
COVERED CHARGES	12,792,760.07	CONTRACTUAL ALLOW	9,548,988.61
NON-COVERD CHARGES	205,388.87	TOTAL MEDICAID LIAB	3,243,771.46
		LESS: COB	30,856.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,212,915.01

TOTAL NUMBER OF ADMISSIONS 378

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,095	0	1,173,162.00	172,143.00
ROUTINE NURSERY	62	0	51,274.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	11,067.00
TOTAL ROUTINE	1,157	0	1,224,436.00	183,210.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	618	0	1,361,778.00	0.00
NICU	12	0	18,852.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	1,380,630.00	0.00
TOTAL ACCOMODATIONS	1,787	0	2,605,066.00	183,210.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518,080.78	19.50	OTHER LAB	12,832.00	0.00
MED/SURG SUPPLY	469,829.39	1,251.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,088,247.00	0.00	EDUCATION & TRAINING	195.00	0.00
RADIOLOGY-DIAGNOSTIC	296,013.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	850,259.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	243,984.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	159,110.00	0.00	MRI SERVICES	112,365.35	0.00
IV THERAPY	230,704.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,729,471.00	10,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,204.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,510,647.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,186.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	86,600.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	567,378.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	263,791.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,739.00
LABORATORY PATHOLOGIC	33,040.00	0.00	INJECTABLE DRUGS	894,224.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,227.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	73,620.00	0.00	PATIENT CONVENIENCE	0.00	36.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,640.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	510,112.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,607.51
OTHER IMAGING SERVICE	45,174.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,275.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,889.00	3,508.00			
AUDIOLOGY	3,762.00	903.72			
CARDIOLOGY	135,125.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,076.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,632.00	0.00			

TOTAL ANCILLARY	10,187,694.07	22,178.87
TOTAL ACCOMODATIONS	2,605,066.00	183,210.00
TOTAL CHARGES	12,792,760.07	205,388.87

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 01/01/18 THROUGH 12/31/18
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
951	2018179037151	06/21/18 - 06/25/18	07/02/18	0.00	288.00	0.00	0.00	0.00
-1	2318331000439	09/23/18 - 09/26/18	12/10/18	0.00	2,319.51	0.00	874.26	0.00
TOTAL				0.00	2,607.51	0.00	874.26	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,909.58	ADJUSTMENTS	0.00
COVERED CHARGES	40,909.58	CONTRACTUAL ALLOW	17,998.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	22,911.41
		LESS: COB	22,911.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	2,136.00	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	2,136.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	6,063.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,063.00	0.00
TOTAL ACCOMODATIONS	5	0	8,199.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,489.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	914.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,886.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,295.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,735.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,847.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,768.00	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	3,678.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,440.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,710.58	0.00
TOTAL ACCOMODATIONS	8,199.00	0.00
TOTAL CHARGES	40,909.58	0.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,364,839.69	ADJUSTMENTS	772,688.59
COVERED CHARGES	11,787,307.85	CONTRACTUAL ALLOW	9,996,866.20
NON-COVERD CHARGES	577,531.84	TOTAL MEDICAID LIAB	1,790,441.65
		LESS: COB	3,660.59
		LESS: COPAYMENT	4,373.35
		REIMBURSEMENT	1,782,407.71
		ALL OTHER	1,589,666.96
		FEE SCHEDULE-LAB	176,168.91
		INJECTABLE DRUGS	16,571.84

TOTAL NUMBER OF CLAIMS 4,070

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,805.09	4,102.08	OTHER LAB	77,259.00	3,381.00
MED/SURG SUPPLY	194,110.48	6,243.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	614,021.00	16,147.00	OTHER THERAPEUTIC SVC	0.00	1,840.00
CT SCAN	2,037,426.85	76,417.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264,847.00	37,522.04	FEE SCHEDULE LAB	1,799,483.50	29,771.00
EKG/ECG	338,997.00	21,546.00	MRI SERVICES	194,870.75	6,548.35
IV THERAPY	567,427.00	49,532.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,174,492.76	197,488.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,536.00	0.00	REHAB THERAPY	161.00	0.00
RESPIRATORY SERVICES	46,543.00	25,999.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,330.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	160,210.00	4,330.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,674,679.00	620.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	249,117.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	256,112.81	47,279.19
RADIOLOGY THERAPEUTIC	456.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,556.00	618.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,090.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,025.00	6,600.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	111,474.61	0.00
LITHOTRIPSY	23,751.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	173,241.00	20,316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,388.00	1,657.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,557.00	4,565.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	60,260.00	1,110.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	159,175.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	270,995.00	9,808.00			

TOTAL ANCILLARY	11,787,307.85	577,531.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,787,307.85	577,531.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	134,831.17	ADJUSTMENTS	0.00
COVERED CHARGES	88,756.25	CONTRACTUAL ALLOW	40,346.89
NON-COVERD CHARGES	46,074.92	TOTAL MEDICAID LIAB	48,409.36
		LESS: COB	48,395.52
		LESS: COPAYMENT	13.84
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.80	263.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,526.90	384.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,180.00	895.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,232.35	17,204.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,153.00	1,919.00
EKG/ECG	1,026.00	1,026.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,792.00	178.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,237.25	17,518.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,524.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	119.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,954.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,837.00	256.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,522.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,580.10	679.40
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	51.85	3,258.92
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	776.00	1,588.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,184.00	784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	88,756.25	46,074.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,756.25	46,074.92

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,832.83	ADJUSTMENTS	8,027.48
COVERED CHARGES	415,767.56	CONTRACTUAL ALLOW	394,588.18
NON-COVERD CHARGES	3,065.27	TOTAL MEDICAID LIAB	21,179.38
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	20,444.38
		TOTAL NUMBER OF CLAIMS	329

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,043.98	10.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,438.66	1,069.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,537.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,125.05	875.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,686.00	730.00
EKG/ECG	6,669.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,675.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	290,221.00	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	6,371.87	379.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	415,767.56	3,065.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	415,767.56	3,065.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,560.65	ADJUSTMENTS	0.00
COVERED CHARGES	10,514.65	CONTRACTUAL ALLOW	4,620.11
NON-COVERD CHARGES	46.00	TOTAL MEDICAID LIAB	5,894.54
		LESS: COB	5,888.54
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	975.00	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	2,880.00	10.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	966.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	5,043.00	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	137.65	36.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,514.65	46.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,514.65	46.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	606,563.64	ADJUSTMENTS	49,874.06
COVERED CHARGES	478,002.90	CONTRACTUAL ALLOW	411,460.14
NON-COVERD CHARGES	128,560.74	TOTAL MEDICAID LIAB	66,542.76
		LESS: COB	0.00
		LESS: COPAYMENT	41.06
		REIMBURSEMENT	66,501.70
		TOTAL NUMBER OF CLAIMS	12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,369.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53,395.85	134.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,204.00	5,953.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,368.00	0.00
EKG/ECG	3,078.00	513.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,303.00	1,068.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	206,470.75	114,737.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,713.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,448.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,908.54	5,231.49
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	119,967.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	429.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,980.00	924.00			

TOTAL ANCILLARY	478,002.90	128,560.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	478,002.90	128,560.74

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,853,641.66	ADJUSTMENTS	349,762.35
COVERED CHARGES	13,669,895.36	CONTRACTUAL ALLOW	9,162,545.17
NON-COVERD CHARGES	183,746.30	TOTAL MEDICAID LIAB	4,507,350.19
		LESS: COB	26,395.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,480,954.99

TOTAL NUMBER OF ADMISSIONS 637

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,341	0	860,368.00	66,629.00
ROUTINE NURSERY	265	0	148,717.00	662.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,606	0	1,009,085.00	67,291.00
SPECIAL CARE SERVICES				
CCU	707	0	726,920.00	0.00
ICU	388	0	538,950.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,095	0	1,265,870.00	0.00
TOTAL ACCOMODATIONS	2,701	0	2,274,955.00	67,291.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,278,185.95	1,726.96	OTHER LAB	53,182.00	0.00
MED/SURG SUPPLY	1,071,142.14	3,665.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,179,184.00	672.00	EDUCATION & TRAINING	5,077.00	0.00
RADIOLOGY-DIAGNOSTIC	196,405.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	669,877.00	13,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,573.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	126,317.00	0.00	MRI SERVICES	59,433.00	0.00
IV THERAPY	196,221.24	720.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	657,212.00	1,843.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	198,568.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,073,481.00	3,740.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,078.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	94,303.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	438,828.00	1,272.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	73,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	38,266.00	0.00	INJECTABLE DRUGS	575.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,082.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,128.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	442,170.00	54,621.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	322.00	19,679.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	457,932.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	91,828.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	179,452.00	6,480.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	115,726.00	8,336.00			
AUDIOLOGY	15,116.00	0.00			
CARDIOLOGY	216,315.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,026.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	208,679.00	0.00			

TOTAL ANCILLARY	11,394,940.36	116,455.30
TOTAL ACCOMODATIONS	2,274,955.00	67,291.00
TOTAL CHARGES	13,669,895.36	183,746.30

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,197.27	ADJUSTMENTS	0.00
COVERED CHARGES	40,425.27	CONTRACTUAL ALLOW	5,684.22
NON-COVERD CHARGES	2,772.00	TOTAL MEDICAID LIAB	34,741.05
		LESS: COB	34,741.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	5,817.00	570.00
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	5,817.00	570.00
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	5,817.00	570.00

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,946.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,380.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,286.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,252.00	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	653.00	0.00	PROFESSIONAL FEES	0.00	2,202.00
OPERATING ROOM	5,266.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	263.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	784.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	347.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84.00	0.00			

TOTAL ANCILLARY	34,608.27	2,202.00
TOTAL ACCOMODATIONS	5,817.00	570.00
TOTAL CHARGES	40,425.27	2,772.00

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,099,508.26	ADJUSTMENTS	567,065.47
COVERED CHARGES	8,871,785.31	CONTRACTUAL ALLOW	6,972,503.68
NON-COVERD CHARGES	1,227,722.95	TOTAL MEDICAID LIAB	1,899,281.63
		LESS: COB	751.18
		LESS: COPAYMENT	5,955.13
		REIMBURSEMENT	1,892,575.32
		ALL OTHER	1,298,586.51
		FEE SCHEDULE-LAB	221,678.98
		INJECTABLE DRUGS	372,309.83

TOTAL NUMBER OF CLAIMS 5,052

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286,893.56	570.48	OTHER LAB	88,847.00	0.00
MED/SURG SUPPLY	381,244.86	5,289.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,227.00
RADIOLOGY-DIAGNOSTIC	324,420.00	15,667.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,255,908.00	87,681.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,905.00	8,359.05	FEE SCHEDULE LAB	1,328,590.86	98,993.00
EKG/ECG	126,603.00	711.00	MRI SERVICES	195,228.00	20,648.00
IV THERAPY	259,504.00	66,479.00	PROFESSIONAL FEES	0.00	2,955.00
OPERATING ROOM	503,335.38	80,798.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,167.50	19,506.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,482.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	186,466.00	75,152.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	867,233.00	5,689.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,295,445.64	386,660.46
RADIOLOGY THERAPEUTIC	25,360.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,571.00	1,758.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,960.00	954.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	345,887.00	51,739.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,677.00	179,256.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	102.00
OTHER IMAGING SERVICE	159,001.00	6,455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,680.00	5,826.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	289,327.00	43,840.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	248,582.00	56,861.00			
AMBULATORY SURGERY	1,322.88	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,395.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	233,848.00	4,546.00			

TOTAL ANCILLARY	8,871,785.31	1,227,722.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,871,785.31	1,227,722.95

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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
9636	5917338000543	10/11/17 - 10/11/17	12/11/17	0.00	102.00	0.00	0.00	0.00
TOTAL				0.00	102.00	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

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	172,516.34	ADJUSTMENTS	0.00
COVERED CHARGES	119,325.58	CONTRACTUAL ALLOW	15,970.48
NON-COVERD CHARGES	53,190.76	TOTAL MEDICAID LIAB	103,355.10
		LESS: COB	103,308.88
		LESS: COPAYMENT	46.22
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,218.50	591.50	OTHER LAB	3,138.00	0.00
MED/SURG SUPPLY	6,960.88	791.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,839.00	1,617.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,609.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,508.00	2,224.00
EKG/ECG	1,422.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,621.00	392.00	PROFESSIONAL FEES	0.00	15,783.00
OPERATING ROOM	15,103.00	10,768.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,666.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,947.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,014.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,258.00	359.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,528.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,886.20	11,956.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,376.00	6,130.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,411.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,633.00	168.00			

TOTAL ANCILLARY	119,325.58	53,190.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,325.58	53,190.76

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,568.16	ADJUSTMENTS	8,008.90
COVERED CHARGES	397,300.85	CONTRACTUAL ALLOW	379,075.25
NON-COVERD CHARGES	21,267.31	TOTAL MEDICAID LIAB	18,225.60
		LESS: COB	0.00
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	17,679.60

TOTAL NUMBER OF CLAIMS 291

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,696.06	0.00	OTHER LAB	1,199.00	0.00
MED/SURG SUPPLY	11,117.00	263.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,376.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,294.00	8,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	669.02	FEE SCHEDULE LAB	99,558.00	4,294.00
EKG/ECG	6,873.00	0.00	MRI SERVICES	3,003.00	0.00
IV THERAPY	13,284.00	1,372.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,414.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,851.00	157.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,722.79	4,772.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	707.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,429.00	1,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,777.00	0.00			

TOTAL ANCILLARY	397,300.85	21,267.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	397,300.85	21,267.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,581.16	ADJUSTMENTS	0.00
COVERED CHARGES	5,689.40	CONTRACTUAL ALLOW	1,954.57
NON-COVERD CHARGES	2,891.76	TOTAL MEDICAID LIAB	3,734.83
		LESS: COB	3,731.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	248.00	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	1,355.00	28.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	434.00	0.00	PROFESSIONAL FEES	0.00	2,684.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,571.00	132.00	SPECIAL SERVICES	0.00	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	47.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	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	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,689.40	2,891.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,689.40	2,891.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	540,250.47	ADJUSTMENTS	27,182.00
COVERED CHARGES	464,115.21	CONTRACTUAL ALLOW	360,743.81
NON-COVERD CHARGES	76,135.26	TOTAL MEDICAID LIAB	103,371.40
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	103,323.40

TOTAL NUMBER OF CLAIMS 19

GEORGIA 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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,232.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,764.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,889.00	11,607.00	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	1,453.00	438.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,210.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	356,456.45	53,624.26
RADIOLOGY THERAPEUTIC	4,681.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,087.00	207.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	9,473.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	511.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	625.00	786.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	464,115.21	76,135.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	464,115.21	76,135.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,820,740.21	ADJUSTMENTS	207,308.21
COVERED CHARGES	19,811,788.21	CONTRACTUAL ALLOW	12,781,201.01
NON-COVERD CHARGES	8,952.00	TOTAL MEDICAID LIAB	7,030,587.20
		LESS: COB	29,713.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,000,873.25

TOTAL NUMBER OF ADMISSIONS 1,440

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,582	0	10,346,906.00	0.00
ROUTINE NURSERY	106	0	80,984.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,688	0	10,427,890.00	0.00
SPECIAL CARE SERVICES				
CCU	354	0	684,062.00	0.00
ICU	160	0	476,160.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	514	0	1,160,222.00	0.00
TOTAL ACCOMODATIONS	9,202	0	11,588,112.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,525,725.39	0.00	OTHER LAB	34,629.25	0.00
MED/SURG SUPPLY	153,675.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,997,823.78	0.00	EDUCATION & TRAINING	5,570.00	0.00
RADIOLOGY-DIAGNOSTIC	124,172.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	430,424.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,913.94	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	93,394.00	0.00	MRI SERVICES	135,891.00	0.00
IV THERAPY	203,931.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,817.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,514.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555,038.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,959.00	0.00	AMBULANCE	0.00	2,568.00
GI SERVICES	70,286.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	683,548.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,025.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,587.00	0.00	INJECTABLE DRUGS	783,780.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	295.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,564.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,252.00	5,796.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,472.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	11,160.00	0.00	IMPL DEV CHARGE PATIENTS	159,970.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,689.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	73,003.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,445.00	0.00			
AUDIOLOGY	2,576.00	0.00			
CARDIOLOGY	552,966.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,652.00	588.00			

TOTAL ANCILLARY	8,223,676.21	8,952.00
TOTAL ACCOMODATIONS	11,588,112.00	0.00
TOTAL CHARGES	19,811,788.21	8,952.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	109,687.35	ADJUSTMENTS	0.00
COVERED CHARGES	109,687.35	CONTRACTUAL ALLOW	64,138.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	45,549.05
		LESS: COB	45,549.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	26	0	31,226.00	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	31,226.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	3,858.00	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	3,858.00	0.00
TOTAL ACCOMODATIONS	28	0	35,084.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,814.99	0.00	OTHER LAB	1,513.00	0.00
MED/SURG SUPPLY	3,640.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,203.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,002.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	538.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	943.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,446.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	269.96	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,150.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,588.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,603.35	0.00
TOTAL ACCOMODATIONS	35,084.00	0.00
TOTAL CHARGES	109,687.35	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,489,873.51	ADJUSTMENTS	363,496.27
COVERED CHARGES	9,871,702.61	CONTRACTUAL ALLOW	7,868,382.88
NON-COVERD CHARGES	618,170.90	TOTAL MEDICAID LIAB	2,003,319.73
		LESS: COB	2,350.27
		LESS: COPAYMENT	4,641.00
		REIMBURSEMENT	1,996,328.46
		ALL OTHER	1,829,285.12
		FEE SCHEDULE-LAB	99,319.51
		INJECTABLE DRUGS	67,723.83

TOTAL NUMBER OF CLAIMS 3,195

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	289,042.78	0.00	OTHER LAB	76,751.50	0.00
MED/SURG SUPPLY	106,869.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,895.00
RADIOLOGY-DIAGNOSTIC	369,647.00	8,608.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,109,525.00	108,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,495.00	19,614.00	FEE SCHEDULE LAB	1,110,095.00	26,240.00
EKG/ECG	118,626.00	4,304.00	MRI SERVICES	274,419.00	18,594.00
IV THERAPY	715,861.00	65,656.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	483,463.44	45,846.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103,782.00	1,530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,517.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	223,542.00	2,639.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,750,734.28	13,610.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,029.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	672,147.59	108,747.78
RADIOLOGY THERAPEUTIC	914.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	497.00	1,988.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,932.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	299.00	3,506.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,087,232.00	1,240.00	IMPL DEV CHARGE PATIENTS	31,275.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,969.00	38,567.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,394.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	230,276.00	43,755.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	424,288.00	48,553.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	101,521.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	254,490.00	52,281.00			

TOTAL ANCILLARY	9,871,702.61	618,170.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,871,702.61	618,170.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	222,983.48	ADJUSTMENTS	0.00
COVERED CHARGES	165,855.43	CONTRACTUAL ALLOW	44,786.56
NON-COVERD CHARGES	57,128.05	TOTAL MEDICAID LIAB	121,068.87
		LESS: COB	120,975.87
		LESS: COPAYMENT	93.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,839.46	75.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	218.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,527.00	1,337.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,265.00	19,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,106.00	1,095.00
EKG/ECG	807.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,982.00	167.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,460.50	1,902.50	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	2,758.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,546.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	714.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,446.07	24,982.55
RADIOLOGY THERAPEUTIC	1,548.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	14,508.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,175.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,638.00	1,650.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,785.00	730.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,035.00	1,885.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,872.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	2,494.00			

TOTAL ANCILLARY	165,855.43	57,128.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	165,855.43	57,128.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	359,398.89	ADJUSTMENTS	541.40
COVERED CHARGES	356,032.94	CONTRACTUAL ALLOW	342,103.88
NON-COVERD CHARGES	3,365.95	TOTAL MEDICAID LIAB	13,929.06
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	13,560.06
		TOTAL NUMBER OF CLAIMS	249

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,088.16	0.00	OTHER LAB	806.00	0.00
MED/SURG SUPPLY	291.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,593.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,818.00	1,896.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,638.00	824.00
EKG/ECG	2,152.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,850.00	334.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,400.00	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	173,978.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,499.74	311.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,918.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	356,032.94	3,365.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	356,032.94	3,365.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,615.48	ADJUSTMENTS	0.00
COVERED CHARGES	13,753.48	CONTRACTUAL ALLOW	-2,657.57
NON-COVERD CHARGES	10,862.00	TOTAL MEDICAID LIAB	16,411.05
		LESS: COB	16,405.05
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	71.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	756.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,533.00	66.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,302.00	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	8,428.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	438.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,753.48	10,862.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,753.48	10,862.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,540,123.30	ADJUSTMENTS	80,526.86
COVERED CHARGES	2,493,353.15	CONTRACTUAL ALLOW	1,607,464.16
NON-COVERD CHARGES	46,770.15	TOTAL MEDICAID LIAB	885,888.99
		LESS: COB	26,173.56
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	859,283.43

TOTAL NUMBER OF CLAIMS 154

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,729.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,952.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	135.00
RADIOLOGY-DIAGNOSTIC	2,608.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,876.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	555.00	FEE SCHEDULE LAB	16,522.20	851.00
EKG/ECG	3,497.00	538.00	MRI SERVICES	0.00	0.00
IV THERAPY	131,597.00	5,835.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	137,611.50	19,379.50	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	20,430.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,528.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,231.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,618.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,930,156.06	926.65
RADIOLOGY THERAPEUTIC	5,072.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	47,539.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,980.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	57,152.00	12,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,780.00	0.00			

TOTAL ANCILLARY	2,493,353.15	46,770.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,493,353.15	46,770.15

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,979.04	ADJUSTMENTS	0.00
COVERED CHARGES	163,979.04	CONTRACTUAL ALLOW	95,472.63
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	68,506.41
		LESS: COB	68,497.41
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	980.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	157,815.94	0.00
RADIOLOGY THERAPEUTIC	4,850.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	163,979.04	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	163,979.04	0.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,507,070.83	ADJUSTMENTS	80,400.41
COVERED CHARGES	5,483,462.83	CONTRACTUAL ALLOW	3,970,542.01
NON-COVERD CHARGES	23,608.00	TOTAL MEDICAID LIAB	1,512,920.82
		LESS: COB	13,148.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,499,772.16

TOTAL NUMBER OF ADMISSIONS 187

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	663	0	393,822.00	18,182.00
ROUTINE NURSERY	56	0	20,548.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	719	0	414,370.00	18,182.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	173	0	249,700.00	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	173	0	249,700.00	0.00
TOTAL ACCOMODATIONS	892	0	664,070.00	18,182.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,183,521.88	0.00	OTHER LAB	14,505.00	0.00
MED/SURG SUPPLY	843,927.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	500,462.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	278,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,179.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,962.00	0.00	MRI SERVICES	20,220.00	0.00
IV THERAPY	66,750.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	640,686.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,972.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	245,968.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,990.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,423.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,007.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,652.00	0.00	INJECTABLE DRUGS	4,758.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,256.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,593.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,580.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,426.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	382,955.00	0.00
LITHOTRIPSY	22,298.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,460.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,847.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,452.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,766.00	0.00			
AMBULATORY SURGERY	8,602.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,541.64	0.00			

TOTAL ANCILLARY	4,819,392.83	5,426.00
TOTAL ACCOMODATIONS	664,070.00	18,182.00
TOTAL CHARGES	5,483,462.83	23,608.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,976.00	ADJUSTMENTS	0.00
COVERED CHARGES	120,612.00	CONTRACTUAL ALLOW	54,545.49
NON-COVERD CHARGES	364.00	TOTAL MEDICAID LIAB	66,066.51
		LESS: COB	66,066.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	7,722.00	364.00
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	7,722.00	364.00
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	7,722.00	364.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,720.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,364.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,437.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,126.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,049.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	965.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,542.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	171.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,468.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	670.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.00	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	1,982.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,890.00	0.00
TOTAL ACCOMODATIONS	7,722.00	364.00
TOTAL CHARGES	120,612.00	364.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,628,191.35	ADJUSTMENTS	332,282.42
COVERED CHARGES	4,081,399.69	CONTRACTUAL ALLOW	3,274,185.08
NON-COVERD CHARGES	546,791.66	TOTAL MEDICAID LIAB	807,214.61
		LESS: COB	1,340.25
		LESS: COPAYMENT	2,128.30
		REIMBURSEMENT	803,746.06
		ALL OTHER	726,819.78
		FEE SCHEDULE-LAB	66,629.13
		INJECTABLE DRUGS	10,297.15

TOTAL NUMBER OF CLAIMS 2,042

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253,868.04	7,940.99	OTHER LAB	18,352.00	0.00
MED/SURG SUPPLY	489,565.55	1,251.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161,733.00	4,861.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	597,201.00	159,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,281.00	3,852.00	FEE SCHEDULE LAB	536,331.00	56,490.00
EKG/ECG	50,182.00	5,054.00	MRI SERVICES	88,933.00	0.00
IV THERAPY	124,538.00	66,655.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	267,764.00	56,582.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,616.00	1,236.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,733.00	16,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,744.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	599,592.00	5,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,810.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	135,333.25	68,185.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	548.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,332.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,217.00	306.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,377.00	34,974.00
LITHOTRIPSY	194,693.00	594.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	84,877.00	11,564.00			
BLOOD	2,091.00	0.00			
BLOOD STORAGE & PRO.	9,927.00	3,485.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,302.00	9,339.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,658.00	9,797.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,680.85	21,593.00			

TOTAL ANCILLARY	4,081,399.69	546,791.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,081,399.69	546,791.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,053.05	ADJUSTMENTS	0.00
COVERED CHARGES	102,481.05	CONTRACTUAL ALLOW	35,813.58
NON-COVERD CHARGES	46,572.00	TOTAL MEDICAID LIAB	66,667.47
		LESS: COB	66,659.31
		LESS: COPAYMENT	8.16
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 49

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,218.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,610.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,924.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,297.00	13,315.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	340.00	FEE SCHEDULE LAB	14,945.00	3,092.00
EKG/ECG	875.00	0.00	MRI SERVICES	3,646.00	15,148.00
IV THERAPY	5,951.00	3,160.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,322.00	3,346.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,710.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	348.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,092.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,276.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,050.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,820.00	3,375.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	533.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	303.00
LITHOTRIPSY	11,149.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,588.00	1,961.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,999.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,659.98	0.00			

TOTAL ANCILLARY	102,481.05	46,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	102,481.05	46,572.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	806,054.35	ADJUSTMENTS	4,189.32
COVERED CHARGES	693,592.35	CONTRACTUAL ALLOW	662,210.01
NON-COVERD CHARGES	112,462.00	TOTAL MEDICAID LIAB	31,382.34
		LESS: COB	0.00
		LESS: COPAYMENT	1,194.00
		REIMBURSEMENT	30,188.34
		TOTAL NUMBER OF CLAIMS	561

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,328.00	170.00	OTHER LAB	5,510.00	0.00
MED/SURG SUPPLY	36,355.56	529.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,342.00	2,768.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	143,934.00	64,964.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	539.00	FEE SCHEDULE LAB	90,846.00	10,300.00
EKG/ECG	10,661.00	175.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,690.00	12,902.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,310.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	695.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,020.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260,922.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	450.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,918.09	16,192.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	156.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,257.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,097.00	3,226.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	697.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,100.70	0.00			

TOTAL ANCILLARY	693,592.35	112,462.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	693,592.35	112,462.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,571.58	ADJUSTMENTS	0.00
COVERED CHARGES	40,199.58	CONTRACTUAL ALLOW	18,367.69
NON-COVERD CHARGES	9,372.00	TOTAL MEDICAID LIAB	21,831.89
		LESS: COB	21,807.89
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,432.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,727.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	950.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,248.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,465.00	648.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,354.00	173.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,536.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	516.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	912.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,399.00	303.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,257.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	845.44	0.00			

TOTAL ANCILLARY	40,199.58	9,372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,199.58	9,372.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	526,908.35	ADJUSTMENTS	58,761.30
COVERED CHARGES	474,559.35	CONTRACTUAL ALLOW	392,213.73
NON-COVERD CHARGES	52,349.00	TOTAL MEDICAID LIAB	82,345.62
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	82,270.62

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,301.00	368.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	88,538.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,106.00	842.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	736.00	FEE SCHEDULE LAB	6,509.00	526.00
EKG/ECG	1,743.00	350.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	303.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,091.00	3,268.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,239.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,297.00	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	8,318.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,677.07	3,260.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	644.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,756.00	42,696.00
LITHOTRIPSY	135,242.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,098.00	0.00			

TOTAL ANCILLARY	474,559.35	52,349.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	474,559.35	52,349.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	268,317.47	ADJUSTMENTS	0.00
COVERED CHARGES	264,406.47	CONTRACTUAL ALLOW	162,609.29
NON-COVERD CHARGES	3,911.00	TOTAL MEDICAID LIAB	101,797.18
		LESS: COB	2,698.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,099.18

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	66	0	39,348.00	3,138.00
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	66	0	39,348.00	3,138.00
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	66	0	39,348.00	3,138.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,299.61	0.00	OTHER LAB	765.00	0.00
MED/SURG SUPPLY	22,836.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,476.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,336.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,032.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,044.00	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	837.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,320.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	884.00	773.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,228.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	225,058.47	773.00
TOTAL ACCOMODATIONS	39,348.00	3,138.00
TOTAL CHARGES	264,406.47	3,911.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,664,991.82	ADJUSTMENTS	100,792.38
COVERED CHARGES	1,545,317.70	CONTRACTUAL ALLOW	1,067,802.44
NON-COVERD CHARGES	119,674.12	TOTAL MEDICAID LIAB	477,515.26
		LESS: COB	0.00
		LESS: COPAYMENT	470.62
		REIMBURSEMENT	477,044.64
		ALL OTHER	433,781.32
		FEE SCHEDULE-LAB	39,204.90
		INJECTABLE DRUGS	4,058.42

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,367.14	437.97	OTHER LAB	3,060.00	0.00
MED/SURG SUPPLY	31,808.85	363.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,789.00	1,795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	309,436.00	39,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,378.00	880.00	FEE SCHEDULE LAB	385,943.50	25,856.00
EKG/ECG	25,144.00	2,536.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,760.00	10,780.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,304.00	8,110.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,780.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	479,789.00	9,397.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	76,632.21	13,602.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,478.46
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,478.00	1,279.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,069.00	773.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,456.00	2,614.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,306.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,817.00	356.00			

TOTAL ANCILLARY	1,545,317.70	119,674.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,545,317.70	119,674.12

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,125.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,554.00	CONTRACTUAL ALLOW	4,430.63
NON-COVERD CHARGES	2,571.00	TOTAL MEDICAID LIAB	11,123.37
		LESS: COB	11,120.37
		LESS: COPAYMENT	3.00
		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 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 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	288.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,575.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,115.00	198.00
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	537.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	798.00	798.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,816.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,554.00	2,571.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,554.00	2,571.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	58,511.97	ADJUSTMENTS	117.00
COVERED CHARGES	55,131.80	CONTRACTUAL ALLOW	52,461.80
NON-COVERD CHARGES	3,380.17	TOTAL MEDICAID LIAB	2,670.00
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	2,589.00
		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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,409.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	722.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,216.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,439.00	1,575.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,099.00	770.00
EKG/ECG	804.00	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	72.00	244.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	108.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,859.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,403.43	791.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,131.80	3,380.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,131.80	3,380.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,141,217.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,131,792.94	CONTRACTUAL ALLOW	1,644,013.33
NON-COVERD CHARGES	9,424.14	TOTAL MEDICAID LIAB	487,779.61
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	487,779.61

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	20	0	13,872.63	998.55
ROUTINE NURSERY	11	0	4,074.73	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	17,947.36	998.55
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	122	0	204,197.26	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	122	0	204,197.26	0.00
TOTAL ACCOMODATIONS	153	0	222,144.62	998.55

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,960.88	0.00	OTHER LAB	17,208.14	0.00
MED/SURG SUPPLY	57,500.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	229,514.03	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,605.71	0.00	OTHER THERAPEUTIC SVC	0.00	550.36
CT SCAN	112,899.07	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,785.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,031.79	0.00	MRI SERVICES	30,185.12	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	246,059.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	299,869.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	171,653.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,666.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107,147.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,928.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	956.11	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,804.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,711.98	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	960.65	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	584.32	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,790.83	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,673.38	0.00			
BLOOD	7,274.88	0.00			
BLOOD STORAGE & PRO.	8,901.98	7,713.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,293.89	162.11			
AUDIOLOGY	746.68	0.00			
CARDIOLOGY	68,933.79	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,909,648.32	8,425.59
TOTAL ACCOMODATIONS	222,144.62	998.55
TOTAL CHARGES	2,131,792.94	9,424.14

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,436,091.50	ADJUSTMENTS	38,363.69
COVERED CHARGES	1,809,170.51	CONTRACTUAL ALLOW	1,595,707.18
NON-COVERD CHARGES	626,920.99	TOTAL MEDICAID LIAB	213,463.33
		LESS: COB	0.00
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	213,031.33
		ALL OTHER	192,272.03
		FEE SCHEDULE-LAB	17,838.30
		INJECTABLE DRUGS	2,921.00

TOTAL NUMBER OF CLAIMS 571

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,771.20	40,152.79	OTHER LAB	30,711.94	0.00
MED/SURG SUPPLY	18,416.26	666.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,886.46	39,515.28	OTHER THERAPEUTIC SVC	0.00	8,264.30
CT SCAN	102,352.00	235,182.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	777.28	FEE SCHEDULE LAB	316,919.47	27,831.15
EKG/ECG	55,384.49	635.37	MRI SERVICES	5,543.98	10,284.40
IV THERAPY	8,242.57	2,769.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,773.92	36,709.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,251.27	9,158.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,525.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,240.49	21,298.44	CAST ROOM	0.00	0.00
EMERGENCY ROOM	815,625.15	59,223.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,959.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,899.15	9,509.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	842.58	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,340.28	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	854.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	732.18	9,201.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,915.11	3,324.16			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,343.46	1,928.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,899.35	34,803.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,379.57	68,933.79			
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	99,396.86	3,714.67			

TOTAL ANCILLARY	1,809,170.51	626,920.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,809,170.51	626,920.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	216,252.91	ADJUSTMENTS	1,279.56
COVERED CHARGES	181,307.07	CONTRACTUAL ALLOW	176,943.75
NON-COVERD CHARGES	34,945.84	TOTAL MEDICAID LIAB	4,363.32
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	4,174.32
		TOTAL NUMBER OF CLAIMS	78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,482.20	2,370.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	276.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,440.60	5,822.81	OTHER THERAPEUTIC SVC	0.00	275.18
CT SCAN	4,373.04	23,450.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,371.26	1,819.03
EKG/ECG	6,353.70	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	933.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,171.49	552.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,905.09	207.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	447.76			

TOTAL ANCILLARY	181,307.07	34,945.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	181,307.07	34,945.84

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	174,009.69	ADJUSTMENTS	0.00
COVERED CHARGES	172,972.07	CONTRACTUAL ALLOW	156,650.27
NON-COVERD CHARGES	1,037.62	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	16,312.80

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338.84	751.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,844.75	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	1,995.26	31.11
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,776.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,657.22	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	10,569.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,940.95	255.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,030.06	0.00
LITHOTRIPSY	54,819.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	172,972.07	1,037.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	172,972.07	1,037.62

GEORGIA DEPARTMENT OF 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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,711,910.28	ADJUSTMENTS	57,952.82
COVERED CHARGES	3,691,764.74	CONTRACTUAL ALLOW	2,908,905.10
NON-COVERD CHARGES	20,145.54	TOTAL MEDICAID LIAB	782,859.64
		LESS: COB	941.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	781,917.90

TOTAL NUMBER OF ADMISSIONS 89

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	102	0	72,666.99	5,858.16
ROUTINE NURSERY	30	0	11,112.90	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	132	0	83,779.89	5,858.16
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	186	0	270,839.44	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	186	0	270,839.44	0.00
TOTAL ACCOMODATIONS	318	0	354,619.33	5,858.16

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512,561.67	0.00	OTHER LAB	40,035.49	0.00
MED/SURG SUPPLY	83,238.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	563,217.36	0.00	EDUCATION & TRAINING	244.27	0.00
RADIOLOGY-DIAGNOSTIC	118,052.64	0.00	OTHER THERAPEUTIC SVC	0.00	4,645.98
CT SCAN	250,228.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,597.37	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	49,805.65	0.00	MRI SERVICES	62,273.31	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	281,898.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,225.22	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	430,531.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	183,892.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,603.49	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	302,394.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,199.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,899.58	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,460.37	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,558.97	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,645.85	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,752.96	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,807.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,851.42	0.00			
BLOOD	1,818.72	0.00			
BLOOD STORAGE & PRO.	10,628.57	9,641.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,426.71	0.00			
CARDIOLOGY	217,296.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,337,145.41	14,287.38
TOTAL ACCOMODATIONS	354,619.33	5,858.16
TOTAL CHARGES	3,691,764.74	20,145.54

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,126.01	ADJUSTMENTS	0.00
COVERED CHARGES	7,126.01	CONTRACTUAL ALLOW	806.57
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,319.44
		LESS: COB	6,319.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	644.04	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	1	0	644.04	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	1	0	644.04	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,019.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,624.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,741.74	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.68	0.00	FREE STANDING CLINIC	0.00	0.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,481.97	0.00
TOTAL ACCOMODATIONS	644.04	0.00
TOTAL CHARGES	7,126.01	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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,189,952.25	ADJUSTMENTS	209,914.68
COVERED CHARGES	5,767,868.47	CONTRACTUAL ALLOW	5,350,545.27
NON-COVERD CHARGES	422,083.78	TOTAL MEDICAID LIAB	417,323.20
		LESS: COB	620.83
		LESS: COPAYMENT	1,047.00
		REIMBURSEMENT	415,655.37
		ALL OTHER	362,557.21
		FEE SCHEDULE-LAB	46,911.60
		INJECTABLE DRUGS	6,186.56

TOTAL NUMBER OF CLAIMS 1,494

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153,919.61	3,904.39	OTHER LAB	44,784.06	0.00
MED/SURG SUPPLY	62,099.95	2,452.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	82.02
RADIOLOGY-DIAGNOSTIC	305,354.27	4,137.86	OTHER THERAPEUTIC SVC	0.00	34,884.76
CT SCAN	626,042.96	126,306.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,472.00	2,250.96	FEE SCHEDULE LAB	717,448.45	26,564.66
EKG/ECG	135,451.84	635.37	MRI SERVICES	46,648.53	0.00
IV THERAPY	6,886.65	2,643.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	333,128.14	21,231.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	204.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,136.04	19,195.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	151,056.55	7,719.88	AMBULANCE	0.00	0.00
GI SERVICES	51,849.72	1,186.01	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,292,253.04	32,589.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	146,644.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	152,716.17	42,108.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	706.64	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,365.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,020.84	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.16	4,838.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,147.81	1,171.36
LITHOTRIPSY	54,819.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,050.00	5,950.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,878.88	1,928.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,544.30	30,715.34			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,335.43	30,637.24			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154,893.86	12,857.82			

TOTAL ANCILLARY	5,767,868.47	422,083.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,767,868.47	422,083.78

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 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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,418.03	ADJUSTMENTS	0.00
COVERED CHARGES	115,626.34	CONTRACTUAL ALLOW	65,109.68
NON-COVERD CHARGES	68,791.69	TOTAL MEDICAID LIAB	50,516.66
		LESS: COB	50,510.66
		LESS: COPAYMENT	6.00
		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

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697.12	8,146.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,455.38	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,014.70	2,044.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,707.33	4,075.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,141.38	251.80
EKG/ECG	635.37	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,347.61	22,945.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	889.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,684.70	14,268.19	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,187.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,394.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,977.20	367.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	142.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	16,362.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,493.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	115,626.34	68,791.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,626.34	68,791.69

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	729,525.02	ADJUSTMENTS	644.28
COVERED CHARGES	692,714.43	CONTRACTUAL ALLOW	678,488.11
NON-COVERD CHARGES	36,810.59	TOTAL MEDICAID LIAB	14,226.32
		LESS: COB	28.18
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	13,709.14
		TOTAL NUMBER OF CLAIMS	263

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,249.99	1,040.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	829.02	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,360.68	6,852.05	OTHER THERAPEUTIC SVC	0.00	2,751.80
CT SCAN	60,751.27	16,934.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,633.77	3,336.75
EKG/ECG	24,779.43	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	6,394.18	1,866.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	441,027.56	2,218.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,323.77	829.07
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,364.76	793.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	692,714.43	36,810.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	692,714.43	36,810.59

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,426.49	ADJUSTMENTS	0.00
COVERED CHARGES	24,240.90	CONTRACTUAL ALLOW	12,937.24
NON-COVERD CHARGES	5,185.59	TOTAL MEDICAID LIAB	11,303.66
		LESS: COB	11,294.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.70	13.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	753.72	0.00	OTHER THERAPEUTIC SVC	0.00	275.18
CT SCAN	0.00	4,707.33	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,050.86	189.58
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	17,349.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,060.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,240.90	5,185.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,240.90	5,185.59

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

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,433,143.28	ADJUSTMENTS	17,158.91
COVERED CHARGES	2,427,529.51	CONTRACTUAL ALLOW	2,083,662.46
NON-COVERD CHARGES	5,613.77	TOTAL MEDICAID LIAB	343,867.05
		LESS: COB	1,611.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	342,255.14

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	91,537.80	2,307.81
ROUTINE NURSERY	13	0	10,123.74	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	96	0	101,661.54	2,307.81
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	34	0	52,749.88	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	34	0	52,749.88	0.00
TOTAL ACCOMODATIONS	130	0	154,411.42	2,307.81

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218,318.86	0.00	OTHER LAB	3,392.35	0.00
MED/SURG SUPPLY	63,538.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	355,376.39	0.00	EDUCATION & TRAINING	186.02	0.00
RADIOLOGY-DIAGNOSTIC	14,845.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	82,486.83	1,914.43	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,796.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,504.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,260.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	628,864.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,724.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,034.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,004.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,275.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,264.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,633.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	16,146.71	0.00	INJECTABLE DRUGS	424,391.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,988.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,185.35	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,220.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,559.47	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,908.14	1,135.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,046.28	255.65			
AUDIOLOGY	1,415.70	0.00			
CARDIOLOGY	11,068.50	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	5,680.74	0.00			

TOTAL ANCILLARY	2,273,118.09	3,305.96
TOTAL ACCOMODATIONS	154,411.42	2,307.81
TOTAL CHARGES	2,427,529.51	5,613.77

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,686,263.11	ADJUSTMENTS	189,094.65
COVERED CHARGES	5,285,073.33	CONTRACTUAL ALLOW	4,778,822.86
NON-COVERD CHARGES	401,189.78	TOTAL MEDICAID LIAB	506,250.47
		LESS: COB	16.65
		LESS: COPAYMENT	1,767.00
		REIMBURSEMENT	504,466.82
		ALL OTHER	389,513.23
		FEE SCHEDULE-LAB	70,806.56
		INJECTABLE DRUGS	44,147.03

TOTAL NUMBER OF CLAIMS 1,610

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,362.59	3,345.29	OTHER LAB	172,102.16	3,596.14
MED/SURG SUPPLY	14,431.50	201.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,370.97	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150,661.12	3,014.67	OTHER THERAPEUTIC SVC	0.00	1,429.60
CT SCAN	568,555.14	27,845.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,241.44	10,181.11	FEE SCHEDULE LAB	1,512,948.43	72,812.29
EKG/ECG	57,467.13	1,680.68	MRI SERVICES	223,863.32	5,618.34
IV THERAPY	14,540.40	1,614.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	405,836.28	62,028.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,337.66	0.00	REHAB THERAPY	2,678.76	0.00
RESPIRATORY SERVICES	36,906.17	3,242.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,803.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	172,178.79	42,953.43	CAST ROOM	0.00	0.00
EMERGENCY ROOM	743,299.39	2,815.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	107,770.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	457,576.73	131,532.70
RADIOLOGY THERAPEUTIC	6,538.95	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	464.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,253.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	364.94	582.56	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,137.20	386.45
LITHOTRIPSY	70,416.21	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,996.10	2,335.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	52,093.19	10,279.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	81,829.14	11,068.50			
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	28,672.34	0.00			

TOTAL ANCILLARY	5,285,073.33	401,189.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,285,073.33	401,189.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,786.67	ADJUSTMENTS	0.00
COVERED CHARGES	20,677.00	CONTRACTUAL ALLOW	9,408.83
NON-COVERD CHARGES	1,109.67	TOTAL MEDICAID LIAB	11,268.17
		LESS: COB	11,265.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,123.68	186.02	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	6,956.13	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,484.72	167.78
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,168.83	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	4,750.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,979.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	145.64	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	610.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,213.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,677.00	1,109.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,677.00	1,109.67

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	178,901.65	ADJUSTMENTS	1,217.92
COVERED CHARGES	173,735.56	CONTRACTUAL ALLOW	170,759.46
NON-COVERD CHARGES	5,166.09	TOTAL MEDICAID LIAB	2,976.10
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	2,919.10
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,365.18	27.49	OTHER LAB	1,966.16	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	3,949.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,657.62	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,732.84	2,138.83
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,876.99	117.18	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,985.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,338.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,096.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,783.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,857.37	1,899.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,849.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,396.84	983.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,054.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	825.41	0.00			

TOTAL ANCILLARY	173,735.56	5,166.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	173,735.56	5,166.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	682,502.51	ADJUSTMENTS	49,178.34
COVERED CHARGES	670,249.01	CONTRACTUAL ALLOW	621,043.67
NON-COVERD CHARGES	12,253.50	TOTAL MEDICAID LIAB	49,205.34
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	49,178.34
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,764.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,933.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,074.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,842.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,571.82	210.92
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	604.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	440,744.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	289.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,396.09	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,125.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,224.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,381.72	11,269.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	15,790.26	772.90
LITHOTRIPSY	23,472.07	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,033.49	0.00			

TOTAL ANCILLARY	670,249.01	12,253.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	670,249.01	12,253.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,739,754.00	ADJUSTMENTS	40,644.82
COVERED CHARGES	8,445,435.00	CONTRACTUAL ALLOW	3,436,136.70
NON-COVERD CHARGES	294,319.00	TOTAL MEDICAID LIAB	5,009,298.30
		LESS: COB	774.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,008,523.42

TOTAL NUMBER OF ADMISSIONS 1,226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,547	0	3,882,900.00	273,000.00
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	5,547	0	3,882,900.00	273,000.00
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	5,547	0	3,882,900.00	273,000.00

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,708,441.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	792,477.00	635.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,916.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,908.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,772.00	0.00	MRI SERVICES	5,470.00	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	247.00	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	180.00	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	NO CC/INVALID REV CODE	0.00	20,684.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124.00	0.00			

TOTAL ANCILLARY	4,562,535.00	21,319.00
TOTAL ACCOMODATIONS	3,882,900.00	273,000.00
TOTAL CHARGES	8,445,435.00	294,319.00

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 01/01/18 THROUGH 12/31/18
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
25	2218040008770	01/30/18 - 02/05/18	02/12/18	0.00	2,549.00	0.00	0.00	0.00
3001	2218082007692	03/16/18 - 03/19/18	03/26/18	0.00	194.00	0.00	0.00	0.00
3001	2218082009201	03/15/18 - 03/19/18	03/26/18	0.00	316.00	0.00	0.00	0.00
25	2218089006383	03/18/18 - 03/26/18	04/02/18	0.00	4,383.00	0.00	0.00	0.00
25	2218145006657	05/15/18 - 05/21/18	05/28/18	0.00	3,591.00	0.00	0.00	0.00
780	2218164000669	05/18/18 - 05/22/18	06/18/18	0.00	34.00	0.00	0.00	0.00
3901	2218183006165	06/23/18 - 06/26/18	07/09/18	0.00	378.00	0.00	0.00	0.00
2501	2218304013734	10/18/18 - 10/24/18	11/05/18	0.00	8,861.00	0.00	0.00	0.00
3011	2219002002957	12/22/18 - 12/26/18	01/07/19	0.00	378.00	0.00	0.00	0.00
TOTAL				0.00	20,684.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,268.00	ADJUSTMENTS	246.46
COVERED CHARGES	55,930.00	CONTRACTUAL ALLOW	37,409.16
NON-COVERD CHARGES	338.00	TOTAL MEDICAID LIAB	18,520.84
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	18,346.84
		ALL OTHER	18,346.84
		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 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	17,344.00	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	27,248.00	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	338.00
EKG/ECG	247.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,091.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,930.00	338.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,930.00	338.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,743,633.89	ADJUSTMENTS	1,463,301.92
COVERED CHARGES	48,068,389.46	CONTRACTUAL ALLOW	37,449,185.86
NON-COVERD CHARGES	1,675,244.43	TOTAL MEDICAID LIAB	10,619,203.60
		LESS: COB	81,871.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,537,332.41

TOTAL NUMBER OF ADMISSIONS 1,207

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,935	0	4,070,718.00	565,554.00
ROUTINE NURSERY	1,163	0	1,960,776.00	427,977.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	2.00
TOTAL ROUTINE	5,098	0	6,031,494.00	993,533.00
SPECIAL CARE SERVICES				
CCU	607	0	1,937,596.00	0.00
ICU	446	0	1,423,216.00	0.00
NICU	76	0	302,236.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,129	0	3,663,048.00	0.00
TOTAL ACCOMODATIONS	6,227	0	9,694,542.00	993,533.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,505,876.78	26,382.17	OTHER LAB	468,984.00	815.00
MED/SURG SUPPLY	973,102.86	11,588.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,009,130.40	118,518.00	EDUCATION & TRAINING	8,820.00	136.00
RADIOLOGY-DIAGNOSTIC	889,705.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,444,027.00	12,180.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	384,068.11	10,092.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	314,496.00	0.00	MRI SERVICES	582,426.00	3,383.00
IV THERAPY	39,753.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,987,340.00	44,387.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,467,004.00	182,126.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,282,798.00	25,835.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	470,367.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	482,972.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,789,897.00	4,380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	593,624.00	3,427.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	251,880.00	482.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	59,156.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	233,340.77	7,742.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	131,962.60	614.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,013,711.00	78,418.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,224.00	18,419.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	877,121.34	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	434,657.00	5,416.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	524,482.00	69,546.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	234,835.00	57,345.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,413,622.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	127,922.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	365,542.60	480.00			

TOTAL ANCILLARY	38,373,847.46	681,711.43
TOTAL ACCOMODATIONS	9,694,542.00	993,533.00
TOTAL CHARGES	48,068,389.46	1,675,244.43

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,708.17	ADJUSTMENTS	0.00
COVERED CHARGES	179,753.17	CONTRACTUAL ALLOW	104,054.98
NON-COVERD CHARGES	4,955.00	TOTAL MEDICAID LIAB	75,698.19
		LESS: COB	75,698.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	20	0	21,120.00	4,387.00
ROUTINE NURSERY	11	0	17,349.00	568.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	38,469.00	4,955.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	3,151.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	3,151.00	0.00
TOTAL ACCOMODATIONS	32	0	41,620.00	4,955.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,092.35	0.00	OTHER LAB	1,887.00	0.00
MED/SURG SUPPLY	1,443.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,034.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,656.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,048.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	832.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,695.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,472.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,232.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,117.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,970.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,446.00	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	203.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,364.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,824.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,284.00	0.00			

TOTAL ANCILLARY	138,133.17	0.00
TOTAL ACCOMODATIONS	41,620.00	4,955.00
TOTAL CHARGES	179,753.17	4,955.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,296,395.95	ADJUSTMENTS	383,512.21
COVERED CHARGES	19,616,650.58	CONTRACTUAL ALLOW	17,355,349.76
NON-COVERD CHARGES	4,679,745.37	TOTAL MEDICAID LIAB	2,261,300.82
		LESS: COB	59,660.26
		LESS: COPAYMENT	3,862.28
		REIMBURSEMENT	2,197,778.28
		ALL OTHER	1,959,760.86
		FEE SCHEDULE-LAB	194,669.85
		INJECTABLE DRUGS	43,347.57

TOTAL NUMBER OF CLAIMS 5,121

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325,434.20	0.00	OTHER LAB	399,727.00	4,441.00
MED/SURG SUPPLY	352,856.63	80,024.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	40.00	EDUCATION & TRAINING	0.00	408.00
RADIOLOGY-DIAGNOSTIC	993,884.00	180,263.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,063,588.00	729,356.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,747.00	23,262.13	FEE SCHEDULE LAB	3,041,272.50	169,884.00
EKG/ECG	352,352.00	5,824.00	MRI SERVICES	186,949.00	147,995.00
IV THERAPY	44,366.00	744.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,022,886.00	387,951.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	140,903.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,733.00	24,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	232,444.00	3,616.00	AMBULANCE	0.00	0.00
GI SERVICES	182,168.00	106,800.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,290,175.00	178,625.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	308,417.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	455,308.27	491,979.03
RADIOLOGY THERAPEUTIC	184,942.00	226,436.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	53,394.00	30,753.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,632.00	18,150.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	66,216.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	93,070.00	17,894.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	137,576.74	534,544.31
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	639,891.00	207,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	87,833.00	63,274.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	119,151.00	217,940.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	294,243.00	735,473.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	72,588.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	391,119.24	25,853.00			

TOTAL ANCILLARY	19,616,650.58	4,679,745.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,616,650.58	4,679,745.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	397,767.15	ADJUSTMENTS	0.00
COVERED CHARGES	295,302.88	CONTRACTUAL ALLOW	212,189.39
NON-COVERD CHARGES	102,464.27	TOTAL MEDICAID LIAB	83,113.49
		LESS: COB	83,097.85
		LESS: COPAYMENT	15.64
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,103.18	0.00	OTHER LAB	3,774.00	0.00
MED/SURG SUPPLY	12,668.08	394.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,373.00	1,773.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,088.00	16,290.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,022.00	3,294.00
EKG/ECG	2,912.00	416.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,179.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,754.00	46,602.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,883.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,067.00	4,417.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,477.00	3,820.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,252.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,157.17	3,887.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	142.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,809.45	262.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,986.00	9,892.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	11,416.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,462.00	0.00			

TOTAL ANCILLARY	295,302.88	102,464.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	295,302.88	102,464.27

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	780,128.67	ADJUSTMENTS	329.64
COVERED CHARGES	708,119.00	CONTRACTUAL ALLOW	689,714.74
NON-COVERD CHARGES	72,009.67	TOTAL MEDICAID LIAB	18,404.26
		LESS: COB	0.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	17,885.26
		TOTAL NUMBER OF CLAIMS	329

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,051.58	166.40	OTHER LAB	5,661.00	0.00
MED/SURG SUPPLY	5,817.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,583.00	8,920.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,122.00	22,718.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	123,079.00	5,697.00
EKG/ECG	6,240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,974.00	14,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	351.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,016.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,337.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	410,982.00	4,185.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,234.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,785.91	2,208.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,759.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,980.00	9,246.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,587.00	1,861.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,318.40	0.00			

TOTAL ANCILLARY	708,119.00	72,009.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	708,119.00	72,009.67

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,230.33	ADJUSTMENTS	0.00
COVERED CHARGES	22,753.73	CONTRACTUAL ALLOW	17,914.01
NON-COVERD CHARGES	3,476.60	TOTAL MEDICAID LIAB	4,839.72
		LESS: COB	4,818.72
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	357.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,286.00	598.00
EKG/ECG	416.00	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	15,922.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.69	15.60
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,753.73	3,476.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,753.73	3,476.60

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	967,334.12	ADJUSTMENTS	21,723.40
COVERED CHARGES	783,387.71	CONTRACTUAL ALLOW	728,719.21
NON-COVERD CHARGES	183,946.41	TOTAL MEDICAID LIAB	54,668.50
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	54,608.50
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,463.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,321.14	1,565.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,134.00	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	3,524.00	368.00
EKG/ECG	832.00	416.00	MRI SERVICES	0.00	0.00
IV THERAPY	449.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	140,964.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	580.00	614.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,736.00	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	6,084.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	477,596.31	30,486.79
RADIOLOGY THERAPEUTIC	8,940.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	96,262.24	81,162.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	69,030.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,502.00	304.00			

TOTAL ANCILLARY	783,387.71	183,946.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	783,387.71	183,946.41

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,322.16	ADJUSTMENTS	0.00
COVERED CHARGES	51,674.07	CONTRACTUAL ALLOW	44,220.62
NON-COVERD CHARGES	23,648.09	TOTAL MEDICAID LIAB	7,453.45
		LESS: COB	7,450.45
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,369.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	880.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	794.00	40.00
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	13,076.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,028.00	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	3,617.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	418.92	164.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,543.78	7,904.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,440.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	51,674.07	23,648.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,674.07	23,648.09

** 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,876,841.78	ADJUSTMENTS	1,322,485.20
COVERED CHARGES	63,104,843.87	CONTRACTUAL ALLOW	53,126,543.42
NON-COVERD CHARGES	11,771,997.91	TOTAL MEDICAID LIAB	9,978,300.45
		LESS: COB	105,265.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,873,035.10

TOTAL NUMBER OF ADMISSIONS 1,234

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,455	0	11,409,393.83	11,173,085.88
ROUTINE NURSERY	454	0	757,357.96	123,857.80
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,909	0	12,166,751.79	11,296,943.68
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,251	0	3,985,495.51	16,714.49
NICU	6	0	25,540.38	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,257	0	4,011,035.89	16,714.49
TOTAL ACCOMODATIONS	9,166	0	16,177,787.68	11,313,658.17

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,832,692.81	24,229.26	OTHER LAB	305,873.31	0.00
MED/SURG SUPPLY	2,269,553.05	12,878.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,553,936.43	46,188.12	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	841,118.95	6,171.61	OTHER THERAPEUTIC SVC	0.00	3,622.50
CT SCAN	2,854,590.49	56,778.91	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	663,053.46	27,474.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	688,502.55	799.17	MRI SERVICES	583,751.49	0.00
IV THERAPY	1,513.59	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,418,158.54	70,516.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	519,339.39	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,075,485.84	38,769.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	664,019.41	3,367.79	AMBULANCE	0.00	0.00
GI SERVICES	506,141.46	13,332.77	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,441,634.37	9,086.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	533,173.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,259.93
LABORATORY PATHOLOGIC	263,717.31	0.00	INJECTABLE DRUGS	6,535,464.35	19,145.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	490,275.34	14,622.48	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	369,908.97	33,043.54	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	372,404.74	1,925.09	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,951.19	612.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	54,992.20	0.00	IMPL DEV CHARGE PATIENTS	1,434,197.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	252,999.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	149,890.93	66,264.29			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	805,317.58	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,151,620.24	5,251.53			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,587.41	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	168,190.13	0.00			

TOTAL ANCILLARY	46,927,056.19	458,339.74
TOTAL ACCOMODATIONS	16,177,787.68	11,313,658.17
TOTAL CHARGES	63,104,843.87	11,771,997.91

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	55,904.35	ADJUSTMENTS	0.00
COVERED CHARGES	55,532.38	CONTRACTUAL ALLOW	41,353.37
NON-COVERD CHARGES	371.97	TOTAL MEDICAID LIAB	14,179.01
		LESS: COB	14,179.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	4,605.00	371.97
ROUTINE NURSERY	8	0	6,795.52	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	11,400.52	371.97
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	11,400.52	371.97

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,243.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	205.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,459.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	857.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,993.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	799.17	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,901.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	372.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	916.93	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,687.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	446.99	0.00	INJECTABLE DRUGS	5,960.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	288.27	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	44,131.86	0.00
TOTAL ACCOMODATIONS	11,400.52	371.97
TOTAL CHARGES	55,532.38	371.97

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,768,620.04	ADJUSTMENTS	120,106.94
COVERED CHARGES	17,413,804.34	CONTRACTUAL ALLOW	16,021,550.79
NON-COVERD CHARGES	2,354,815.70	TOTAL MEDICAID LIAB	1,392,253.55
		LESS: COB	6,480.14
		LESS: COPAYMENT	2,654.03
		REIMBURSEMENT	1,383,119.38
		ALL OTHER	1,275,301.59
		FEE SCHEDULE-LAB	92,604.87
		INJECTABLE DRUGS	15,212.92

TOTAL NUMBER OF CLAIMS 3,177

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,096.15	234,550.66	OTHER LAB	163,920.80	0.00
MED/SURG SUPPLY	265,405.50	21,029.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	219.36
RADIOLOGY-DIAGNOSTIC	650,540.24	95,761.60	OTHER THERAPEUTIC SVC	0.00	523.67
CT SCAN	2,192,990.16	277,319.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,459.33	42,011.01	FEE SCHEDULE LAB	3,740,365.26	159,028.19
EKG/ECG	407,576.64	2,279.11	MRI SERVICES	163,757.41	59,182.47
IV THERAPY	819,859.18	46,003.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	569,523.43	239,960.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,510.23	4,529.76	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,874.13	17,447.38	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	329,573.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	100,539.97	30,610.95	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,834,750.38	36,002.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	704,526.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,249.58
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391,929.07	158,659.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,392.31	13,010.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,778.54	10,048.13	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,315.11	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110,042.02	7,542.54	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	92,256.65	0.00	IMPL DEV CHARGE PATIENTS	155,484.25	8,457.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,751.68
OTHER IMAGING SERVICE	296,310.91	242,462.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,670.96	2,209.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	494,774.65	269,541.54			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	184,189.32	223,244.94			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,654.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	264,051.99	129,860.62			

TOTAL ANCILLARY	17,413,804.34	2,354,815.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,413,804.34	2,354,815.70

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 09/01/17 THROUGH 08/31/18
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	2218235001394	02/01/18 - 02/01/18	08/27/18	0.00	4,751.68	0.00	0.00	0.00
TOTAL				0.00	4,751.68	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	428,099.39	ADJUSTMENTS	0.00
COVERED CHARGES	343,622.87	CONTRACTUAL ALLOW	271,769.63
NON-COVERD CHARGES	84,476.52	TOTAL MEDICAID LIAB	71,853.24
		LESS: COB	71,801.16
		LESS: COPAYMENT	52.08
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,567.87	2,885.99	OTHER LAB	2,590.70	0.00
MED/SURG SUPPLY	22,165.50	6,946.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,905.93	1,599.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,658.34	7,692.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,894.68	1,365.98
EKG/ECG	5,534.99	0.00	MRI SERVICES	5,548.59	0.00
IV THERAPY	11,846.74	548.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,011.08	40,891.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,792.74	1,221.36	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,450.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,789.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,788.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,091.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,828.47	1,761.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	360.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,741.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,492.27	9,362.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,178.81			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,992.71			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,562.18	5,029.60			

TOTAL ANCILLARY	343,622.87	84,476.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	343,622.87	84,476.52

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,537,594.87	ADJUSTMENTS	4,898.37
COVERED CHARGES	1,420,716.64	CONTRACTUAL ALLOW	1,398,407.61
NON-COVERD CHARGES	116,878.23	TOTAL MEDICAID LIAB	22,309.03
		LESS: COB	0.00
		LESS: COPAYMENT	639.00
		REIMBURSEMENT	21,670.03
		TOTAL NUMBER OF CLAIMS	383

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,108.71	13,777.00	OTHER LAB	8,861.39	0.00
MED/SURG SUPPLY	1,414.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,230.58	12,285.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	95,760.97	34,690.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	927.77	FEE SCHEDULE LAB	400,950.64	8,646.36
EKG/ECG	31,049.23	0.00	MRI SERVICES	0.00	10,494.78
IV THERAPY	61,047.23	806.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,005.31	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	720,499.92	1,131.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,933.98	15,964.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	726.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,389.27	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,205.99	13,795.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,242.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,471.21	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,176.73	0.00			

TOTAL ANCILLARY	1,420,716.64	116,878.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,420,716.64	116,878.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,021.67	ADJUSTMENTS	0.00
COVERED CHARGES	40,591.76	CONTRACTUAL ALLOW	27,758.69
NON-COVERD CHARGES	33,429.91	TOTAL MEDICAID LIAB	12,833.07
		LESS: COB	12,821.07
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,048.44	1,846.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	734.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,911.55	15,016.82	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,900.67	10,054.56
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	5,548.59
IV THERAPY	1,370.33	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	22,074.78	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	234.87	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	963.04			
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	1,216.62	0.00			

TOTAL ANCILLARY	40,591.76	33,429.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,591.76	33,429.91

GEORGIA 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	247,479.66	ADJUSTMENTS	5,559.47
COVERED CHARGES	237,989.16	CONTRACTUAL ALLOW	221,301.75
NON-COVERD CHARGES	9,490.50	TOTAL MEDICAID LIAB	16,687.41
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	16,678.41

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,389.31	3,200.09	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34,313.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	563.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,658.34	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,820.66	467.55
EKG/ECG	799.17	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,097.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,487.91	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	408.49	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,072.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,001.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,625.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,229.98	4,727.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	96.09	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,250.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	999.51			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,432.47	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	2,838.78	0.00			

TOTAL ANCILLARY	237,989.16	9,490.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	237,989.16	9,490.50

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,269,370.10	ADJUSTMENTS	2,762.25
COVERED CHARGES	1,844,381.10	CONTRACTUAL ALLOW	1,133,800.70
NON-COVERD CHARGES	424,989.00	TOTAL MEDICAID LIAB	710,580.40
		LESS: COB	17,396.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	693,183.99

TOTAL NUMBER OF ADMISSIONS 171

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,033	0	774,750.00	423,617.00
ROUTINE NURSERY	45	0	31,240.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,078	0	805,990.00	423,617.00
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	1,078	0	805,990.00	423,617.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	650,963.00	0.00	OTHER LAB	2,519.00	0.00
MED/SURG SUPPLY	87,717.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	122,831.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,957.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,688.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,985.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,176.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,913.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,394.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,276.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,228.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	661.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,037.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,915.00	1,372.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	4,640.00	0.00			
CARDIOLOGY	2,048.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	1,038,391.10	1,372.00
TOTAL ACCOMODATIONS	805,990.00	423,617.00
TOTAL CHARGES	1,844,381.10	424,989.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,361,357.00	ADJUSTMENTS	437.67
COVERED CHARGES	1,159,665.20	CONTRACTUAL ALLOW	944,083.24
NON-COVERD CHARGES	201,691.80	TOTAL MEDICAID LIAB	215,581.96
		LESS: COB	0.00
		LESS: COPAYMENT	614.89
		REIMBURSEMENT	214,967.07
		ALL OTHER	174,568.85
		FEE SCHEDULE-LAB	40,263.41
		INJECTABLE DRUGS	134.81

TOTAL NUMBER OF CLAIMS 1,012

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	138,829.30	5,835.80	OTHER LAB	4,235.00	0.00
MED/SURG SUPPLY	97,972.50	1,266.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	41.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,954.00	10,849.00	OTHER THERAPEUTIC SVC	0.00	8,625.00
CT SCAN	59,969.00	14,246.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,122.00	4,183.00	FEE SCHEDULE LAB	435,649.40	23,480.00
EKG/ECG	7,700.00	0.00	MRI SERVICES	5,673.00	0.00
IV THERAPY	2,222.00	99,151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,563.00	10,089.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,821.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,378.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,772.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,805.00	1,090.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,705.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,168.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,049.00	5,688.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	870.00	686.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,231.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,405.00	1,024.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,651.00	14,270.00			

TOTAL ANCILLARY	1,159,665.20	201,691.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,159,665.20	201,691.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,821.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,596.00	CONTRACTUAL ALLOW	6,604.88
NON-COVERD CHARGES	3,225.00	TOTAL MEDICAID LIAB	16,991.12
		LESS: COB	16,991.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,863.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,117.00	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	118.00
CT SCAN	0.00	1,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,177.00	966.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	134.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,363.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,116.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	893.00	801.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,106.00	0.00			

TOTAL ANCILLARY	23,596.00	3,225.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,596.00	3,225.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,632.50	ADJUSTMENTS	0.00
COVERED CHARGES	35,297.50	CONTRACTUAL ALLOW	32,332.68
NON-COVERD CHARGES	2,335.00	TOTAL MEDICAID LIAB	2,964.82
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	2,883.82
		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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,723.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	155.00	104.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,327.00	853.00	OTHER THERAPEUTIC SVC	0.00	938.00
CT SCAN	5,381.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,480.00	243.00
EKG/ECG	70.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	402.00	197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	18,759.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,297.50	2,335.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,297.50	2,335.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,534.50	ADJUSTMENTS	0.00
COVERED CHARGES	56,723.50	CONTRACTUAL ALLOW	45,633.04
NON-COVERD CHARGES	811.00	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	11,087.46

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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,143.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,231.00	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	687.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	710.00	54.00
EKG/ECG	0.00	70.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,319.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,232.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	56,723.50	811.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,723.50	811.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,832,590.74	ADJUSTMENTS	4,655,508.07
COVERED CHARGES	16,107,893.76	CONTRACTUAL ALLOW	10,032,542.83
NON-COVERD CHARGES	724,696.98	TOTAL MEDICAID LIAB	6,075,350.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,075,350.93

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,621	0	3,997,838.00	56,190.00
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	2,621	0	3,997,838.00	56,190.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	59	0	181,838.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	181,838.00	0.00
TOTAL ACCOMODATIONS	2,680	0	4,179,676.00	56,190.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,524,117.00	96,135.00	OTHER LAB	94,561.00	0.00
MED/SURG SUPPLY	2,481,501.07	145,175.98	RECREATIONAL THERAPY	984.00	0.00
LABORATORY-GENERAL	433,440.00	45,087.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164,787.13	0.00	OTHER THERAPEUTIC SVC	16,558.00	12,214.00
CT SCAN	146,082.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	852,086.00	45,000.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,805.00	0.00	MRI SERVICES	56,730.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,334,750.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,060,116.00	207,625.00	FREE STANDING CLINIC	0.00	0.00
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	66,550.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,492,710.00	13,284.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	884,848.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	272,706.00	14,884.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,878.39	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,160.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,393.00	0.00			
AMBULATORY SURGERY	57,485.00	22,552.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,024.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,495.00	0.00			

TOTAL ANCILLARY	11,928,217.76	668,506.98
TOTAL ACCOMODATIONS	4,179,676.00	56,190.00
TOTAL CHARGES	16,107,893.76	724,696.98

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	825,225.14	ADJUSTMENTS	0.00
COVERED CHARGES	819,069.14	CONTRACTUAL ALLOW	661,591.64
NON-COVERD CHARGES	6,156.00	TOTAL MEDICAID LIAB	157,477.50
		LESS: COB	157,477.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	139	0	214,199.00	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	139	0	214,199.00	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	139	0	214,199.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,455.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57,914.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,892.00	0.00	EDUCATION & TRAINING	4,602.00	0.00
RADIOLOGY-DIAGNOSTIC	1,436.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,247.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,608.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	984.00	0.00	MRI SERVICES	3,447.00	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	158,306.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	5,580.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,550.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	52,185.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,609.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	40.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	536.00
OTHER IMAGING SERVICE	1,635.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	604,870.14	6,156.00
TOTAL ACCOMODATIONS	214,199.00	0.00
TOTAL CHARGES	819,069.14	6,156.00

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 04/01/17 THROUGH 03/31/18
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	9718249981008	09/01/17 - 01/18/18	09/17/18	0.00	536.00	0.00	157,477.50	0.00
TOTAL				0.00	536.00	0.00	157,477.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,536,868.29	ADJUSTMENTS	178,154.47
COVERED CHARGES	5,354,028.00	CONTRACTUAL ALLOW	3,598,190.97
NON-COVERD CHARGES	1,182,840.29	TOTAL MEDICAID LIAB	1,755,837.03
		LESS: COB	38,252.02
		LESS: COPAYMENT	4,542.00
		REIMBURSEMENT	1,713,043.01
		ALL OTHER	505,981.85
		FEE SCHEDULE-LAB	29,944.96
		INJECTABLE DRUGS	1,177,116.20

TOTAL NUMBER OF CLAIMS 1,410

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,829.00	23,185.00	OTHER LAB	20,039.00	3,011.00
MED/SURG SUPPLY	39,403.00	0.00	RECREATIONAL THERAPY	328.00	5,506.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	5,047.00
RADIOLOGY-DIAGNOSTIC	16,908.00	5,700.00	OTHER THERAPEUTIC SVC	339.00	5,509.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	190,597.00	222,971.09	FEE SCHEDULE LAB	257,300.00	1,904.00
EKG/ECG	328.00	0.00	MRI SERVICES	366,158.00	84,937.00
IV THERAPY	13,618.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	82.00	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	244.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,701,827.00	429,186.00
RADIOLOGY THERAPEUTIC	126,516.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	93,131.00	226,956.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,939.00	88,849.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	685.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	237,641.00	9,732.00	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	NO CC/INVALID REV CODE	0.00	26,116.00
OTHER IMAGING SERVICE	19,525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	12,333.00	696.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189,059.00	42,606.00			

TOTAL ANCILLARY	5,354,028.00	1,182,840.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,354,028.00	1,182,840.29

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 04/01/17 THROUGH 03/31/18
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	2217207004304	04/11/17 - 04/11/17	07/31/17	0.00	129.00	0.00	0.00	0.00
952	2217207004304	05/08/17 - 05/08/17	07/31/17	0.00	201.00	0.00	0.00	0.00
952	5917283000548	07/12/17 - 07/12/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/25/17 - 07/25/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/17/17 - 07/17/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/26/17 - 07/26/17	10/16/17	0.00	172.00	0.00	0.00	0.00
952	5917283000548	08/08/17 - 08/08/17	10/16/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	09/25/17 - 09/25/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310040825	09/14/17 - 09/14/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310040825	10/19/17 - 10/19/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	10/05/17 - 10/05/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	09/29/17 - 09/29/17	11/13/17	0.00	86.00	0.00	0.00	0.00
952	2017310040825	09/25/17 - 09/25/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310040825	09/22/17 - 09/22/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310040825	09/18/17 - 09/18/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	10/06/17 - 10/06/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310041558	10/23/17 - 10/23/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/20/17 - 10/20/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/06/17 - 10/06/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/05/17 - 10/05/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/25/17 - 10/25/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/17/17 - 10/17/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/11/17 - 10/11/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/13/17 - 10/13/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017312071560	09/29/17 - 09/29/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	09/25/17 - 09/25/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/19/17 - 10/19/17	11/13/17	0.00	67.00	0.00	0.00	0.00
952	2017312071560	10/12/17 - 10/12/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017312071560	10/27/17 - 10/27/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/25/17 - 10/25/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/19/17 - 10/19/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017312071560	10/16/17 - 10/16/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/09/17 - 10/09/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/06/17 - 10/06/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/04/17 - 10/04/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017312071560	10/03/17 - 10/03/17	11/13/17	0.00	258.00	0.00	0.00	0.00
952	2017312071560	10/02/17 - 10/02/17	11/13/17	0.00	86.00	0.00	0.00	0.00
952	2017312071560	10/10/17 - 10/10/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/20/17 - 09/20/17	11/20/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/18/17 - 09/18/17	11/20/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/22/17 - 09/22/17	11/20/17	0.00	129.00	0.00	0.00	0.00
952	5917321011355	09/15/17 - 09/15/17	11/20/17	0.00	43.00	0.00	0.00	0.00

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	5917321011355	09/13/17 - 09/13/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/12/17 - 09/12/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/06/17 - 09/06/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/01/17 - 09/01/17	11/20/17	0.00	86.00	0.00	0.00	0.00
952	2017331032304	09/01/17 - 09/01/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	08/23/17 - 08/23/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	08/09/17 - 08/09/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/03/17 - 08/03/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/31/17 - 07/31/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	07/27/17 - 07/27/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/21/17 - 07/21/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/08/17 - 08/08/17	12/04/17	0.00	129.00	0.00	0.00	0.00
952	2017331032304	09/01/17 - 09/01/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	08/21/17 - 08/21/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	09/06/17 - 09/06/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/30/17 - 08/30/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/23/17 - 08/23/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	08/11/17 - 08/11/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/31/17 - 07/31/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	07/25/17 - 07/25/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	5917339002490	11/01/17 - 11/01/17	12/11/17	0.00	201.00	0.00	0.00	0.00
952	5917339002490	10/12/17 - 10/12/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	11/07/17 - 11/07/17	12/11/17	0.00	134.00	0.00	0.00	0.00
952	5917339002490	11/02/17 - 11/02/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	10/18/17 - 10/18/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	11/07/17 - 11/07/17	12/11/17	0.00	86.00	0.00	0.00	0.00
952	5917339002490	11/03/17 - 11/03/17	12/11/17	0.00	129.00	0.00	0.00	0.00
952	5917339002490	10/31/17 - 10/31/17	12/11/17	0.00	129.00	0.00	0.00	0.00
952	5917339002490	10/30/17 - 10/30/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917339002490	10/23/17 - 10/23/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917339002490	10/04/17 - 10/04/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917355006395	11/06/17 - 11/06/17	12/25/17	0.00	201.00	0.00	0.00	0.00
952	5917355006395	11/16/17 - 11/16/17	12/25/17	0.00	268.00	0.00	0.00	0.00
952	5917355006395	11/10/17 - 11/10/17	12/25/17	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/21/17 - 12/21/17	01/22/18	0.00	268.00	0.00	0.00	0.00
952	2018018076485	11/30/17 - 11/30/17	01/22/18	0.00	268.00	0.00	0.00	0.00
952	2018018076485	12/29/17 - 12/29/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/27/17 - 12/27/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/22/17 - 12/22/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/20/17 - 12/20/17	01/22/18	0.00	129.00	0.00	0.00	0.00
952	2018018076485	12/15/17 - 12/15/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/14/17 - 12/14/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/07/17 - 12/07/17	01/22/18	0.00	129.00	0.00	0.00	0.00
952	2018018076485	11/29/17 - 11/29/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/19/17 - 12/19/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	5918030001998	11/16/17 - 11/16/17	02/05/18	0.00	268.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	5918030001998	12/01/17 - 12/01/17	02/05/18	0.00	129.00	0.00	0.00	0.00
952	5918030001998	11/14/17 - 11/14/17	02/05/18	0.00	129.00	0.00	0.00	0.00
952	5918044001967	12/14/17 - 12/14/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	12/04/17 - 12/04/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	11/21/17 - 11/21/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	11/17/17 - 11/17/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918065001722	01/03/18 - 01/03/18	03/12/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	01/11/18 - 01/11/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	01/10/18 - 01/10/18	03/26/18	0.00	201.00	0.00	0.00	0.00
952	2018079077121	01/03/18 - 01/03/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	02/05/18 - 02/05/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	02/02/18 - 02/02/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/31/18 - 01/31/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/29/18 - 01/29/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/24/18 - 01/24/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/12/18 - 01/12/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/25/18 - 01/25/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	02/01/18 - 02/01/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	01/26/18 - 01/26/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	02/08/18 - 02/08/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/29/18 - 01/29/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/26/18 - 01/26/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/23/18 - 01/23/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018095005628	01/29/18 - 01/29/18	04/09/18	0.00	201.00	0.00	0.00	0.00
952	2018107075535	12/04/17 - 12/04/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/01/17 - 12/01/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/18/17 - 12/18/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/27/17 - 12/27/17	04/23/18	0.00	301.00	0.00	0.00	0.00
952	2018107075535	12/15/17 - 12/15/17	04/23/18	0.00	129.00	0.00	0.00	0.00
952	2018107075535	12/11/17 - 12/11/17	04/23/18	0.00	172.00	0.00	0.00	0.00
952	2018114080142	04/03/18 - 04/03/18	04/30/18	0.00	276.00	0.00	0.00	0.00
952	2018114080142	04/02/18 - 04/02/18	04/30/18	0.00	276.00	0.00	0.00	0.00
952	2018114080142	03/21/18 - 03/21/18	04/30/18	0.00	268.00	0.00	0.00	0.00
952	2018114080142	03/20/18 - 03/20/18	04/30/18	0.00	134.00	0.00	0.00	0.00
952	2018114080142	03/29/18 - 03/29/18	04/30/18	0.00	268.00	0.00	0.00	0.00
952	2018114080142	03/22/18 - 03/22/18	04/30/18	0.00	172.00	0.00	0.00	0.00
952	2018114080142	03/20/18 - 03/20/18	04/30/18	0.00	134.00	0.00	0.00	0.00
952	5918122000924	12/29/17 - 12/29/17	05/07/18	0.00	268.00	0.00	0.00	0.00
952	2218131009106	03/23/18 - 03/23/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/28/18 - 02/28/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/19/18 - 02/19/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/15/18 - 02/15/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/07/18 - 02/07/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/24/18 - 01/24/18	06/18/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/22/18 - 01/22/18	06/18/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/19/18 - 01/19/18	06/18/18	0.00	201.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	5918162001179	01/02/18 - 01/02/18	06/18/18	0.00	201.00	0.00	0.00	0.00
TOTAL				0.00	26,116.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	340,148.00	ADJUSTMENTS	0.00
COVERED CHARGES	243,435.00	CONTRACTUAL ALLOW	92,707.55
NON-COVERD CHARGES	96,713.00	TOTAL MEDICAID LIAB	150,727.45
		LESS: COB	150,430.45
		LESS: COPAYMENT	297.00
		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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.00	920.00	OTHER LAB	1,839.00	1,291.00
MED/SURG SUPPLY	2,667.00	0.00	RECREATIONAL THERAPY	0.00	820.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	777.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	214.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,848.00	34,978.00	FEE SCHEDULE LAB	2,096.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,416.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	168,031.00	52.00
RADIOLOGY THERAPEUTIC	658.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,471.00	30,786.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,653.00	10,253.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	30.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,590.00	682.00	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	NO CC/INVALID REV CODE	0.00	4,874.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,084.00	11,004.00			

TOTAL ANCILLARY	243,435.00	96,713.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	243,435.00	96,713.00

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
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	2018093002086	12/08/17 - 12/08/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	12/01/17 - 12/01/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/15/17 - 11/15/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/10/17 - 11/10/17	04/09/18	0.00	86.00	0.00	15,570.80	0.00
952	2018093002086	11/06/17 - 11/06/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/01/17 - 11/01/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	10/26/17 - 10/26/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/29/17 - 11/29/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/08/17 - 11/08/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/01/17 - 11/01/17	04/09/18	0.00	268.00	0.00	15,570.80	0.00
952	2018178028748	03/30/18 - 03/30/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/20/18 - 03/20/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/26/18 - 03/26/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/23/18 - 03/23/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	5918256000846	11/07/17 - 11/07/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/22/17 - 12/22/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/18/17 - 12/18/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/15/17 - 12/15/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/14/17 - 12/14/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/07/17 - 12/07/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/04/17 - 12/04/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/28/17 - 11/28/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/21/17 - 11/21/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/17/17 - 11/17/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/13/17 - 11/13/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/28/17 - 11/28/17	09/17/18	0.00	129.00	0.00	15,970.00	0.00
TOTAL				0.00	4,874.00	0.00	351,572.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	434,922.00	ADJUSTMENTS	111,404.10
COVERED CHARGES	431,661.00	CONTRACTUAL ALLOW	286,800.57
NON-COVERD CHARGES	3,261.00	TOTAL MEDICAID LIAB	144,860.43
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	144,824.43

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	669.00	2,634.00	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	6,385.00	575.00
EKG/ECG	0.00	0.00	MRI SERVICES	13,164.00	0.00
IV THERAPY	18,271.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	393,056.00	52.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116.00	0.00			

TOTAL ANCILLARY	431,661.00	3,261.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	431,661.00	3,261.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,953,624.38	ADJUSTMENTS	749,617.30
COVERED CHARGES	34,467,566.91	CONTRACTUAL ALLOW	30,558,985.95
NON-COVERD CHARGES	486,057.47	TOTAL MEDICAID LIAB	3,908,580.96
		LESS: COB	65,289.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,843,291.58

TOTAL NUMBER OF ADMISSIONS 567

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,011	0	1,429,881.00	99,811.50
ROUTINE NURSERY	731	0	1,145,971.50	24,975.40
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,742	0	2,575,852.50	124,786.90
SPECIAL CARE SERVICES				
CCU	139	0	349,446.00	0.00
ICU	931	0	4,022,068.00	11,376.80
NICU	63	0	243,124.80	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,133	0	4,614,638.80	11,376.80
TOTAL ACCOMODATIONS	2,875	0	7,190,491.30	136,163.70

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,204,186.60	22,473.30	OTHER LAB	116,047.00	1,866.10
MED/SURG SUPPLY	2,990,803.55	47,025.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,455,334.78	17,933.57	EDUCATION & TRAINING	8,973.70	0.00
RADIOLOGY-DIAGNOSTIC	409,172.30	572.40	OTHER THERAPEUTIC SVC	0.00	1,026.00
CT SCAN	1,084,928.20	107,009.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	237,076.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	139,428.80	0.00	MRI SERVICES	237,397.20	0.00
IV THERAPY	56,246.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,844,143.15	15,631.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,885,902.30	0.00	REHAB THERAPY	134.50	0.00
RESPIRATORY SERVICES	2,799,330.00	5,797.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	422,408.46	0.00	AMBULANCE	0.00	1,038.10
GI SERVICES	160,546.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	572,846.80	2,962.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	442,635.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	160,383.70	0.00	INJECTABLE DRUGS	72,860.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	94,883.35	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	182,584.99	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	167,119.40	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,750.00	418.00	TRAUMA RESPONSE	0.00	20,870.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	476,453.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	184,227.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,609.40	100,669.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	103,434.90	0.00			
AUDIOLOGY	102,263.00	0.00			
CARDIOLOGY	461,419.10	4,600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,842.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,702.40	0.00			

TOTAL ANCILLARY	27,277,075.61	349,893.77
TOTAL ACCOMODATIONS	7,190,491.30	136,163.70
TOTAL CHARGES	34,467,566.91	486,057.47

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,261.83	ADJUSTMENTS	0.00
COVERED CHARGES	138,570.03	CONTRACTUAL ALLOW	96,027.09
NON-COVERD CHARGES	691.80	TOTAL MEDICAID LIAB	42,542.94
		LESS: COB	42,542.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12	0	16,734.00	691.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	16,734.00	691.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	11,376.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	11,376.80	0.00
TOTAL ACCOMODATIONS	14	0	28,110.80	691.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,933.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,163.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,026.20	0.00	EDUCATION & TRAINING	349.00	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	772.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,532.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,217.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,813.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,103.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,797.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,333.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	668.00	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	1,359.73	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	333.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,056.00	0.00			

TOTAL ANCILLARY	110,459.23	0.00
TOTAL ACCOMODATIONS	28,110.80	691.80
TOTAL CHARGES	138,570.03	691.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,482,919.54	ADJUSTMENTS	116,219.79
COVERED CHARGES	6,011,709.90	CONTRACTUAL ALLOW	5,407,372.33
NON-COVERD CHARGES	471,209.64	TOTAL MEDICAID LIAB	604,337.57
		LESS: COB	7,047.98
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	595,609.59
		ALL OTHER	538,008.51
		FEE SCHEDULE-LAB	37,638.72
		INJECTABLE DRUGS	19,962.36

TOTAL NUMBER OF CLAIMS 1,512

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210,674.06	0.00	OTHER LAB	40,138.30	0.00
MED/SURG SUPPLY	357,792.60	294.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228,200.00	2,010.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	790,494.40	74,872.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,963.26	FEE SCHEDULE LAB	973,616.40	47,373.50
EKG/ECG	94,389.10	4,636.20	MRI SERVICES	134,234.30	8,180.00
IV THERAPY	344,428.80	38,408.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	306,026.43	70,151.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,096.00	117.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,061.00	0.00	AMBULANCE	0.00	4,171.20
GI SERVICES	22,211.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,246,533.10	3,210.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,070.80	1,100.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	517,716.24	87,618.75
RADIOLOGY THERAPEUTIC	18,846.20	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	2,609.74	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,961.80	2,362.90	TRAUMA RESPONSE	0.00	7,019.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,698.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	100,744.10	24,148.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,806.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,637.00	6,684.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,456.90	18,388.50			
AMBULATORY SURGERY	169,704.85	60,971.52			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,126.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,851.24	1,112.00			

TOTAL ANCILLARY	6,011,709.90	471,209.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,011,709.90	471,209.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,513.44	ADJUSTMENTS	0.00
COVERED CHARGES	75,013.44	CONTRACTUAL ALLOW	17,109.28
NON-COVERD CHARGES	64,500.00	TOTAL MEDICAID LIAB	57,904.16
		LESS: COB	57,883.16
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,525.80	600.00	OTHER LAB	3,248.00	0.00
MED/SURG SUPPLY	1,490.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,883.00	669.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,313.00	32,637.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,442.60	763.00
EKG/ECG	2,048.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,524.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	21,074.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,620.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,910.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,879.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,558.60	390.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	142.67	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,257.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,851.00	900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,577.10	0.00			

TOTAL ANCILLARY	75,013.44	64,500.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	75,013.44	64,500.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	284,982.20	ADJUSTMENTS	105.88
COVERED CHARGES	259,831.10	CONTRACTUAL ALLOW	253,621.76
NON-COVERD CHARGES	25,151.10	TOTAL MEDICAID LIAB	6,209.34
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	5,987.34
		TOTAL NUMBER OF CLAIMS	111

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,124.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,616.10	302.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,317.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,130.20	21,295.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,240.80	1,934.10
EKG/ECG	3,602.80	0.00	MRI SERVICES	5,824.60	0.00
IV THERAPY	12,443.80	568.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	139,093.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,437.35	1,051.20
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	259,831.10	25,151.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	259,831.10	25,151.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,611.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,591.40	CONTRACTUAL ALLOW	1,059.00
NON-COVERD CHARGES	19.80	TOTAL MEDICAID LIAB	1,532.40
		LESS: COB	1,529.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	816.20	19.80
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	1,775.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,591.40	19.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,591.40	19.80

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,205,362.53	ADJUSTMENTS	10,872.20
COVERED CHARGES	1,072,547.03	CONTRACTUAL ALLOW	1,012,700.43
NON-COVERD CHARGES	132,815.50	TOTAL MEDICAID LIAB	59,846.60
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	59,783.60

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,194.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82,190.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,423.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,647.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,797.25	FEE SCHEDULE LAB	15,401.10	0.00
EKG/ECG	772.70	0.00	MRI SERVICES	6,578.60	0.00
IV THERAPY	36,109.10	13,068.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,214.90	107,514.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,158.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,416.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,122.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,555.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132,436.19	10,167.95
RADIOLOGY THERAPEUTIC	1,624.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	598,587.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,426.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,686.80	267.00			

TOTAL ANCILLARY	1,072,547.03	132,815.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,072,547.03	132,815.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,358,775.56	ADJUSTMENTS	37,649.35
COVERED CHARGES	6,070,246.81	CONTRACTUAL ALLOW	4,827,370.60
NON-COVERD CHARGES	288,528.75	TOTAL MEDICAID LIAB	1,242,876.21
		LESS: COB	3,955.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,238,920.34

TOTAL NUMBER OF ADMISSIONS 145

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	471	0	491,079.00	175,053.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	471	0	491,079.00	175,053.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	71	0	200,301.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	71	0	200,301.00	0.00
TOTAL ACCOMODATIONS	542	0	691,380.00	175,053.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449,029.50	0.00	OTHER LAB	49,680.00	0.00
MED/SURG SUPPLY	211,592.00	500.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,174,968.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166,083.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	351,123.75	106,222.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,365.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	56,166.00	0.00	MRI SERVICES	129,083.50	0.00
IV THERAPY	20,813.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	593,085.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	204,242.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	226,748.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,265.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	261,459.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,324.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,844.00
LABORATORY PATHOLOGIC	8,333.50	0.00	INJECTABLE DRUGS	664,004.09	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,082.73	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,135.31	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	15,413.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	408.00	349.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	224,949.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,201.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,452.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,351.75	559.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	237,067.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,983.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,453.50	0.00			

TOTAL ANCILLARY	5,378,866.81	113,475.75
TOTAL ACCOMODATIONS	691,380.00	175,053.00
TOTAL CHARGES	6,070,246.81	288,528.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,191,644.13	ADJUSTMENTS	26,003.60
COVERED CHARGES	9,100,588.70	CONTRACTUAL ALLOW	8,317,223.46
NON-COVERD CHARGES	1,091,055.43	TOTAL MEDICAID LIAB	783,365.24
		LESS: COB	2,853.23
		LESS: COPAYMENT	1,251.00
		REIMBURSEMENT	779,261.01
		ALL OTHER	692,608.09
		FEE SCHEDULE-LAB	76,122.56
		INJECTABLE DRUGS	10,530.36

TOTAL NUMBER OF CLAIMS 2,470

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,063.04	134,147.63	OTHER LAB	98,037.25	0.00
MED/SURG SUPPLY	103,687.00	885.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,044,297.75	19,608.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,479,088.00	379,248.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,465.25	20,304.29	FEE SCHEDULE LAB	1,963,406.25	121,546.50
EKG/ECG	161,511.75	0.00	MRI SERVICES	43,287.50	30,620.50
IV THERAPY	379,032.25	10,878.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	334,742.01	106,599.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,312.25	8,249.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	141,018.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,951.91	32,823.59	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,376,127.62	17,861.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93,262.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	121,182.37	87,274.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,795.75	21,641.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,515.00	6,585.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,634.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,003.25	4,029.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,608.50	286.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	94,459.75	46,531.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,527.00	2,148.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,613.75	31,061.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	206,630.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	164,962.25	6,089.50			

TOTAL ANCILLARY	9,100,588.70	1,091,055.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,100,588.70	1,091,055.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	153,622.42	ADJUSTMENTS	0.00
COVERED CHARGES	94,357.67	CONTRACTUAL ALLOW	51,583.89
NON-COVERD CHARGES	59,264.75	TOTAL MEDICAID LIAB	42,773.78
		LESS: COB	42,737.78
		LESS: COPAYMENT	36.00
		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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	773.62	1,544.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,829.25	1,835.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,152.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,226.50	7,067.25
EKG/ECG	2,294.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,338.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,036.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	535.25	27,990.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,511.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,017.25	5,593.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,319.05	1,236.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	451.50	227.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,266.00	1,510.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	911.25	559.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,553.00	0.00			

TOTAL ANCILLARY	94,357.67	59,264.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,357.67	59,264.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,053,909.99	ADJUSTMENTS	0.00
COVERED CHARGES	952,805.28	CONTRACTUAL ALLOW	930,597.10
NON-COVERD CHARGES	101,104.71	TOTAL MEDICAID LIAB	22,208.18
		LESS: COB	0.00
		LESS: COPAYMENT	768.00
		REIMBURSEMENT	21,440.18
		TOTAL NUMBER OF CLAIMS	397

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,372.78	10,026.67	OTHER LAB	6,795.00	0.00
MED/SURG SUPPLY	635.25	61.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,731.25	9,334.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	91,290.25	49,348.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229,802.00	4,580.50
EKG/ECG	11,764.50	0.00	MRI SERVICES	0.00	6,722.75
IV THERAPY	37,871.50	1,048.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,660.25	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	403,167.00	711.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,060.00	10,956.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	70.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,655.50	8,244.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	952,805.28	101,104.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	952,805.28	101,104.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,816.37	ADJUSTMENTS	0.00
COVERED CHARGES	16,000.75	CONTRACTUAL ALLOW	11,189.78
NON-COVERD CHARGES	815.62	TOTAL MEDICAID LIAB	4,810.97
		LESS: COB	4,798.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	365.62	OTHER LAB	1,852.25	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	3,706.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,852.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	295.75	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,207.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86.00	450.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,000.75	815.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,000.75	815.62

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,808.85	ADJUSTMENTS	0.00
COVERED CHARGES	185,108.70	CONTRACTUAL ALLOW	168,794.65
NON-COVERD CHARGES	13,700.15	TOTAL MEDICAID LIAB	16,314.05
		LESS: COB	4,746.94
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	11,552.11
		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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,640.25	2,150.46	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37,010.00	78.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,900.00	539.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,932.82	FEE SCHEDULE LAB	7,280.50	0.00
EKG/ECG	465.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,171.20	4,842.80	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	30,729.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,238.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,805.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,473.50	954.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,201.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	4,354.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,040.00	0.00			

TOTAL ANCILLARY	185,108.70	13,700.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,108.70	13,700.15

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,237,557.62	ADJUSTMENTS	8,846.48
COVERED CHARGES	1,237,253.62	CONTRACTUAL ALLOW	954,017.02
NON-COVERD CHARGES	304.00	TOTAL MEDICAID LIAB	283,236.60
		LESS: COB	467.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	282,769.37

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	129	0	125,388.00	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	129	0	125,388.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	7,260.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	7,260.00	0.00
TOTAL ACCOMODATIONS	133	0	132,648.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,996.98	0.00	OTHER LAB	2,346.20	0.00
MED/SURG SUPPLY	105,217.00	304.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	91,938.52	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,617.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,588.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,567.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,672.00	0.00	MRI SERVICES	6,952.00	0.00
IV THERAPY	4,131.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,051.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,844.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,199.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,232.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,774.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	522.00	0.00	INJECTABLE DRUGS	120,802.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,979.49	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	302,495.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,310.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,734.65	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,068.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,104,605.62	304.00
TOTAL ACCOMODATIONS	132,648.00	0.00
TOTAL CHARGES	1,237,253.62	304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,199,688.41	ADJUSTMENTS	31,797.24
COVERED CHARGES	1,076,761.45	CONTRACTUAL ALLOW	887,001.03
NON-COVERD CHARGES	122,926.96	TOTAL MEDICAID LIAB	189,760.42
		LESS: COB	0.00
		LESS: COPAYMENT	753.00
		REIMBURSEMENT	189,007.42
		ALL OTHER	183,883.83
		FEE SCHEDULE-LAB	4,690.85
		INJECTABLE DRUGS	432.74

TOTAL NUMBER OF CLAIMS 390

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,624.12	407.50	OTHER LAB	668.75	0.00
MED/SURG SUPPLY	46,001.50	1,105.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,582.00	857.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,938.40	10,638.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,444.49	2,801.18	FEE SCHEDULE LAB	62,502.39	2,506.14
EKG/ECG	5,712.00	0.00	MRI SERVICES	21,711.00	0.00
IV THERAPY	30,655.00	2,436.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	200,616.07	48,491.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	388.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,861.22	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,188.58	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,524.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,071.25	7,742.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,173.71	1,365.71	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	198.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,872.50	0.00
LITHOTRIPSY	0.00	41,505.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,611.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,036.10	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,504.17	649.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	254,724.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	850.50	0.00			

TOTAL ANCILLARY	1,076,761.45	122,926.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,076,761.45	122,926.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,363.91	ADJUSTMENTS	0.00
COVERED CHARGES	52,059.46	CONTRACTUAL ALLOW	27,189.77
NON-COVERD CHARGES	22,304.45	TOTAL MEDICAID LIAB	24,869.69
		LESS: COB	24,842.69
		LESS: COPAYMENT	27.00
		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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,990.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,741.25	312.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	408.00	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	670.00	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,580.39	18,883.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,379.38	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	6,052.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	366.00	1,954.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,134.00
LITHOTRIPSY	8,301.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,570.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	52,059.46	22,304.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,059.46	22,304.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,557.03	ADJUSTMENTS	0.00
COVERED CHARGES	1,557.03	CONTRACTUAL ALLOW	1,333.27
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	223.76
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	220.76

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	33.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133.93	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	1,377.60	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	12.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,557.03	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,557.03	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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,045.08	ADJUSTMENTS	0.00
COVERED CHARGES	25,045.08	CONTRACTUAL ALLOW	11,177.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	13,867.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,867.96

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	3,456.00	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	3,456.00	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	3,456.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,374.21	0.00	OTHER LAB	946.00	0.00
MED/SURG SUPPLY	1,346.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,118.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128.00	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	2,257.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,184.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335.08	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	559.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,589.08	0.00
TOTAL ACCOMODATIONS	3,456.00	0.00
TOTAL CHARGES	25,045.08	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	498,869.26	ADJUSTMENTS	6,086.95
COVERED CHARGES	458,561.79	CONTRACTUAL ALLOW	277,511.60
NON-COVERD CHARGES	40,307.47	TOTAL MEDICAID LIAB	181,050.19
		LESS: COB	0.00
		LESS: COPAYMENT	643.65
		REIMBURSEMENT	180,406.54
		ALL OTHER	163,406.93
		FEE SCHEDULE-LAB	15,841.40
		INJECTABLE DRUGS	1,158.21

TOTAL NUMBER OF CLAIMS 500

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,413.43	11,661.87	OTHER LAB	15,316.98	0.00
MED/SURG SUPPLY	7,041.69	243.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,346.00	1,895.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,542.00	3,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,468.00	1,298.00	FEE SCHEDULE LAB	96,117.00	3,501.25
EKG/ECG	7,424.00	384.00	MRI SERVICES	2,250.00	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	8,689.22	2,755.06	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,455.10	5,698.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,764.70	5,237.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,106.00	30.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	129.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,885.67	3,575.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	672.00	0.00			

TOTAL ANCILLARY	458,561.79	40,307.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	458,561.79	40,307.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,015.73	ADJUSTMENTS	0.00
COVERED CHARGES	40,445.41	CONTRACTUAL ALLOW	37,895.41
NON-COVERD CHARGES	1,570.32	TOTAL MEDICAID LIAB	2,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,457.00
		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

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518.75	199.87	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	372.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,620.00	150.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,996.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,626.50	311.00
EKG/ECG	512.00	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	891.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,961.03	442.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	947.68	467.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,445.41	1,570.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,445.41	1,570.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,834,949.04	ADJUSTMENTS	610,529.54
COVERED CHARGES	32,176,859.63	CONTRACTUAL ALLOW	24,920,774.85
NON-COVERD CHARGES	658,089.41	TOTAL MEDICAID LIAB	7,256,084.78
		LESS: COB	42,140.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,213,944.00

TOTAL NUMBER OF ADMISSIONS 805

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,585	0	3,240,325.00	301,927.00
ROUTINE NURSERY	436	0	731,659.00	17,451.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,021	0	3,971,984.00	319,378.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	618	0	2,132,438.00	0.00
NICU	29	0	114,811.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	647	0	2,247,249.00	0.00
TOTAL ACCOMODATIONS	3,668	0	6,219,233.00	319,378.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,105,435.85	33,897.64	OTHER LAB	237,500.00	1,833.00
MED/SURG SUPPLY	691,770.90	2,105.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,738,453.00	19,927.00	EDUCATION & TRAINING	17,017.00	0.00
RADIOLOGY-DIAGNOSTIC	617,980.00	504.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,648,683.00	6,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	262,768.39	16,678.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	346,875.00	0.00	MRI SERVICES	410,550.00	0.00
IV THERAPY	3,151.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,070,991.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	456,713.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,192,101.00	20,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	255,125.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	351,573.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,529,875.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	374,141.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	201,980.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	56,064.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	141,206.20	7,194.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	95,357.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,177,948.00	155,468.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,002.00	1,854.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	207,786.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	335,714.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	385,836.00	31,168.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	154,089.00	41,860.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	703,322.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,669.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,948.80	0.00			

TOTAL ANCILLARY	25,957,626.63	338,711.41
TOTAL ACCOMODATIONS	6,219,233.00	319,378.00
TOTAL CHARGES	32,176,859.63	658,089.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	550,538.58	ADJUSTMENTS	0.00
COVERED CHARGES	543,138.58	CONTRACTUAL ALLOW	286,206.14
NON-COVERD CHARGES	7,400.00	TOTAL MEDICAID LIAB	256,932.44
		LESS: COB	256,932.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	66	0	83,886.00	6,534.00
ROUTINE NURSERY	15	0	40,784.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	81	0	124,670.00	6,534.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	9	0	35,631.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	35,631.00	0.00
TOTAL ACCOMODATIONS	90	0	160,301.00	6,534.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,495.00	0.00	OTHER LAB	4,779.00	0.00
MED/SURG SUPPLY	16,997.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,976.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,898.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,251.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,197.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,885.00	0.00	MRI SERVICES	3,189.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,896.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,874.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,315.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,455.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,165.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,501.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,649.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,841.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	209.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,526.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,659.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,390.00	866.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,858.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,785.00	0.00			

TOTAL ANCILLARY	382,837.58	866.00
TOTAL ACCOMODATIONS	160,301.00	6,534.00
TOTAL CHARGES	543,138.58	7,400.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,734,137.46	ADJUSTMENTS	340,168.49
COVERED CHARGES	16,321,717.81	CONTRACTUAL ALLOW	14,516,223.49
NON-COVERD CHARGES	3,412,419.65	TOTAL MEDICAID LIAB	1,805,494.32
		LESS: COB	112,990.34
		LESS: COPAYMENT	4,166.45
		REIMBURSEMENT	1,688,337.53
		ALL OTHER	1,515,119.99
		FEE SCHEDULE-LAB	120,230.27
		INJECTABLE DRUGS	52,987.27

TOTAL NUMBER OF CLAIMS 3,810

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	256,507.14	0.00	OTHER LAB	195,022.00	3,322.00
MED/SURG SUPPLY	444,464.64	58,885.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,547.00
RADIOLOGY-DIAGNOSTIC	697,555.00	113,646.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,453,629.00	575,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,344.00	11,108.02	FEE SCHEDULE LAB	2,122,178.00	186,703.00
EKG/ECG	390,720.00	15,540.00	MRI SERVICES	206,598.00	30,960.00
IV THERAPY	123,284.00	1,340.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	709,699.00	386,067.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,364.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,943.00	140,558.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	144,221.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	433,730.00	216,932.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,176,753.00	286,044.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	260,630.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	520,451.53	213,608.70
RADIOLOGY THERAPEUTIC	339,755.00	511,509.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,599.00	6,829.17	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,566.00	4,500.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	43,617.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	91,119.00	8,516.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,065.51	60,149.04
LITHOTRIPSY	0.00	32,504.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	438,378.00	207,279.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,792.00	23,376.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	122,956.00	92,425.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	514,067.00	136,296.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	114,943.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	384,383.99	43,313.00			

TOTAL ANCILLARY	16,321,717.81	3,412,419.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,321,717.81	3,412,419.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	543,516.46	ADJUSTMENTS	0.00
COVERED CHARGES	357,015.46	CONTRACTUAL ALLOW	210,380.30
NON-COVERD CHARGES	186,501.00	TOTAL MEDICAID LIAB	146,635.16
		LESS: COB	146,563.16
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,240.80	0.00	OTHER LAB	2,427.00	0.00
MED/SURG SUPPLY	19,409.30	1,860.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,707.00	3,555.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,720.00	47,690.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,185.00	10,070.00
EKG/ECG	8,325.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,082.00	65,186.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,410.00	1,452.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,521.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,315.00	13,153.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	129,334.00	5,142.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,364.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,028.90	3,616.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,009.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,108.66	1,456.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,250.00	19,433.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,557.00	2,204.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,799.00	11,683.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,222.80	0.00			

TOTAL ANCILLARY	357,015.46	186,501.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	357,015.46	186,501.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	554,850.70	ADJUSTMENTS	435.52
COVERED CHARGES	493,590.29	CONTRACTUAL ALLOW	480,164.69
NON-COVERD CHARGES	61,260.41	TOTAL MEDICAID LIAB	13,425.60
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	13,194.60
		TOTAL NUMBER OF CLAIMS	240

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,501.88	0.00	OTHER LAB	5,245.00	0.00
MED/SURG SUPPLY	4,278.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,515.00	3,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,778.00	19,493.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,042.00	2,954.00
EKG/ECG	6,105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,118.00	528.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	14,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,033.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,558.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	286,036.00	7,215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,799.35	3,850.41
RADIOLOGY THERAPEUTIC	1,551.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,671.00	9,004.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,793.95	0.00			

TOTAL ANCILLARY	493,590.29	61,260.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	493,590.29	61,260.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,283.43	ADJUSTMENTS	0.00
COVERED CHARGES	26,804.43	CONTRACTUAL ALLOW	19,527.72
NON-COVERD CHARGES	479.00	TOTAL MEDICAID LIAB	7,276.71
		LESS: COB	7,261.71
		LESS: COPAYMENT	15.00
		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 FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	409.52	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	1,514.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,360.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,327.00	80.00
EKG/ECG	555.00	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	13,273.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	365.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,804.43	479.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,804.43	479.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,060,313.10	ADJUSTMENTS	5,329.98
COVERED CHARGES	883,036.25	CONTRACTUAL ALLOW	802,996.55
NON-COVERD CHARGES	177,276.85	TOTAL MEDICAID LIAB	80,039.70
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	79,901.70
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,306.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,374.41	109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504.00	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	5,464.00	3,157.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,695.00	1,495.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,272.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	814.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,257.00	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	3,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	605,666.88	154,393.85
RADIOLOGY THERAPEUTIC	41,157.00	6,210.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	123,349.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,376.00	3,896.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,290.00	446.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,350.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,169.65	1,938.00			

TOTAL ANCILLARY	883,036.25	177,276.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	883,036.25	177,276.85

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,135,014.26	ADJUSTMENTS	0.00
COVERED CHARGES	3,047,234.06	CONTRACTUAL ALLOW	2,696,965.32
NON-COVERD CHARGES	87,780.20	TOTAL MEDICAID LIAB	350,268.74
		LESS: COB	1,823.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	348,445.16

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	228,511.00	87,780.20
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	83	0	228,511.00	87,780.20
SPECIAL CARE SERVICES				
CCU	307	0	1,266,028.56	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	307	0	1,266,028.56	0.00
TOTAL ACCOMODATIONS	390	0	1,494,539.56	87,780.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332,915.30	0.00	OTHER LAB	1,697.85	0.00
MED/SURG SUPPLY	37,269.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	311,876.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,673.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,421.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,001.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	302.00	0.00	MRI SERVICES	5,946.00	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	579,523.10	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	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	67,449.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	64,453.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,520.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,373.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,246.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,158.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,869.10	0.00			

TOTAL ANCILLARY	1,552,694.50	0.00
TOTAL ACCOMODATIONS	1,494,539.56	87,780.20
TOTAL CHARGES	3,047,234.06	87,780.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,120,136.13	ADJUSTMENTS	156,734.65
COVERED CHARGES	9,568,859.03	CONTRACTUAL ALLOW	6,320,442.23
NON-COVERD CHARGES	551,277.10	TOTAL MEDICAID LIAB	3,248,416.80
		LESS: COB	122,525.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,125,890.84

TOTAL NUMBER OF ADMISSIONS 317

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,120	0	1,654,741.00	103,659.00
ROUTINE NURSERY	153	0	229,440.00	62,400.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,273	0	1,884,181.00	166,059.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	142	0	872,306.00	0.00
NICU	88	0	213,840.00	211,200.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	230	0	1,086,146.00	211,200.00
TOTAL ACCOMODATIONS	1,503	0	2,970,327.00	377,259.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312,827.16	9,100.69	OTHER LAB	59,950.00	0.00
MED/SURG SUPPLY	236,152.16	3,322.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,361,199.00	19,110.00	EDUCATION & TRAINING	118.00	0.00
RADIOLOGY-DIAGNOSTIC	124,791.92	3,382.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	556,444.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	145,848.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	41,503.00	0.00	MRI SERVICES	179,752.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	721,594.00	2,174.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	101,235.00	590.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	215,059.00	23,478.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,708.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,534.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	399,122.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,934.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,548.60
LABORATORY PATHOLOGIC	50,427.00	0.00	INJECTABLE DRUGS	788,330.23	2,914.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	75,693.90	4,281.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,462.57	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	83,996.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,552.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	161,675.00	164.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	80,622.00
OTHER IMAGING SERVICE	42,544.00	2,872.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	96,209.00	10,299.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,513.00	10,086.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	344,993.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,658.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,707.00	0.00			

TOTAL ANCILLARY	6,598,532.03	174,018.10
TOTAL ACCOMODATIONS	2,970,327.00	377,259.00
TOTAL CHARGES	9,568,859.03	551,277.10

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2018005069148	12/11/17 - 12/18/17	01/15/18	0.00	8,958.00	0.00	0.00	0.00
615	2318050000048	11/09/17 - 11/15/17	02/26/18	0.00	8,958.00	0.00	2,182.54	0.00
615	2018192076564	02/03/18 - 02/05/18	07/16/18	0.00	8,958.00	0.00	0.00	0.00
614	5218256000144	05/16/18 - 06/06/18	09/17/18	0.00	4,479.00	0.00	7,051.88	0.00
615	2318263000309	12/30/17 - 01/01/18	10/01/18	0.00	8,958.00	0.00	1,654.83	0.00
614	2318264000125	06/26/18 - 06/30/18	10/01/18	0.00	4,479.00	0.00	1,685.58	0.00
615	2318270000275	06/29/18 - 07/02/18	10/08/18	0.00	8,958.00	0.00	990.91	0.00
615	2318281000118	02/13/18 - 02/14/18	10/22/18	0.00	8,958.00	0.00	1,242.78	0.00
615	2219042008578	05/31/18 - 06/05/18	02/18/19	0.00	8,958.00	0.00	0.00	0.00
615	2319225000397	04/17/18 - 04/22/18	08/26/19	0.00	8,958.00	0.00	1,613.87	0.00
TOTAL				0.00	80,622.00	0.00	16,422.39	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,901.25	ADJUSTMENTS	0.00
COVERED CHARGES	24,200.25	CONTRACTUAL ALLOW	4,504.29
NON-COVERD CHARGES	701.00	TOTAL MEDICAID LIAB	19,695.96
		LESS: COB	19,695.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	4,383.00	327.00
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	4,383.00	327.00
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	4,383.00	327.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.58	0.00	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	393.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,394.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,544.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,588.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	412.00	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	1,918.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,530.00	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	921.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	22.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	121.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,514.00	374.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,817.25	374.00
TOTAL ACCOMODATIONS	4,383.00	327.00
TOTAL CHARGES	24,200.25	701.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,736,246.25	ADJUSTMENTS	53,705.13
COVERED CHARGES	2,125,008.17	CONTRACTUAL ALLOW	1,742,092.83
NON-COVERD CHARGES	611,238.08	TOTAL MEDICAID LIAB	382,915.34
		LESS: COB	158.84
		LESS: COPAYMENT	1,044.00
		REIMBURSEMENT	381,712.50
		ALL OTHER	343,498.90
		FEE SCHEDULE-LAB	28,628.28
		INJECTABLE DRUGS	9,585.32

TOTAL NUMBER OF CLAIMS 817

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,428.27	16,944.32	OTHER LAB	14,976.00	936.00
MED/SURG SUPPLY	79,375.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,184.40	27,646.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	261,206.00	201,929.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,987.00	4,350.02	FEE SCHEDULE LAB	306,720.00	12,292.00
EKG/ECG	17,094.00	0.00	MRI SERVICES	172,430.00	48,405.00
IV THERAPY	2,370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	225,183.00	67,690.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,481.00	926.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,002.00	29,828.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	386,422.00	9,590.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,192.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	130,861.50	17,182.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	488.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	690.00	923.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,945.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	717.00	229.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,974.00	12,350.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,958.00
OTHER IMAGING SERVICE	87,316.00	26,276.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,467.00	54,277.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	97,883.00	59,834.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,558.00	239.00			

TOTAL ANCILLARY	2,125,008.17	611,238.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,125,008.17	611,238.08

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2018117070735	04/19/18 - 04/19/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018117070735	04/19/18 - 04/19/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	8,958.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,666.82	ADJUSTMENTS	0.00
COVERED CHARGES	50,428.68	CONTRACTUAL ALLOW	25,708.27
NON-COVERD CHARGES	53,238.14	TOTAL MEDICAID LIAB	24,720.41
		LESS: COB	24,691.17
		LESS: COPAYMENT	29.24
		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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,329.24	1,872.49	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,070.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,699.00	364.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,514.00	14,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,414.00	457.00
EKG/ECG	770.00	0.00	MRI SERVICES	0.00	8,958.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,664.00	17,860.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	237.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,615.00	108.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,715.44	361.65
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	405.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	758.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	104.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	5,699.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,738.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,274.00	0.00			

TOTAL ANCILLARY	50,428.68	53,238.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	50,428.68	53,238.14

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,031.10	ADJUSTMENTS	387.78
COVERED CHARGES	22,807.18	CONTRACTUAL ALLOW	21,789.06
NON-COVERD CHARGES	1,223.92	TOTAL MEDICAID LIAB	1,018.12
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	991.12
		TOTAL NUMBER OF CLAIMS	17

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	46.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,276.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,497.00	105.00
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	177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,606.00	234.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,439.18	185.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	699.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,807.18	1,223.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,807.18	1,223.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,453.92	ADJUSTMENTS	0.00
COVERED CHARGES	1,373.00	CONTRACTUAL ALLOW	118.17
NON-COVERD CHARGES	80.92	TOTAL MEDICAID LIAB	1,254.83
		LESS: COB	1,251.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	36.00	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	1,337.00	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	80.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,373.00	80.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,373.00	80.92

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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,370.31	ADJUSTMENTS	5,788.39
COVERED CHARGES	60,907.93	CONTRACTUAL ALLOW	49,313.15
NON-COVERD CHARGES	3,462.38	TOTAL MEDICAID LIAB	11,594.78
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	11,582.78

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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	491.66	82.11	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,280.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,644.02	FEE SCHEDULE LAB	1,771.00	104.00
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	36,480.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,994.00	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	3,102.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,987.27	541.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,091.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	5,509.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	60,907.93	3,462.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,907.93	3,462.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,478,504.45	ADJUSTMENTS	15,358.54
COVERED CHARGES	2,360,579.74	CONTRACTUAL ALLOW	1,258,271.91
NON-COVERD CHARGES	117,924.71	TOTAL MEDICAID LIAB	1,102,307.83
		LESS: COB	10,963.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,091,344.39

TOTAL NUMBER OF ADMISSIONS 204

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,361	0	677,778.00	84,840.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,361	0	677,778.00	84,840.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	92	0	101,518.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	101,518.00	0.00
TOTAL ACCOMODATIONS	1,453	0	779,296.00	84,840.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	196,752.60	0.00	OTHER LAB	1,381.00	0.00
MED/SURG SUPPLY	67,339.39	45.43	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	488,262.00	1,458.00	EDUCATION & TRAINING	56.00	0.00
RADIOLOGY-DIAGNOSTIC	24,788.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,015.00	5,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,195.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,210.00	0.00	MRI SERVICES	13,511.00	0.00
IV THERAPY	187,801.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,211.00	9,386.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,745.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,046.00	2,920.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	278,886.00	435.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	317.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,437.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,260.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,225.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,778.00	13,140.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,550.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	836.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,727.00	0.00			

TOTAL ANCILLARY	1,581,283.74	33,084.71
TOTAL ACCOMODATIONS	779,296.00	84,840.00
TOTAL CHARGES	2,360,579.74	117,924.71

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,338,209.29	ADJUSTMENTS	78,746.51
COVERED CHARGES	1,250,446.48	CONTRACTUAL ALLOW	924,138.74
NON-COVERD CHARGES	87,762.81	TOTAL MEDICAID LIAB	326,307.74
		LESS: COB	172.60
		LESS: COPAYMENT	975.00
		REIMBURSEMENT	325,160.14
		ALL OTHER	268,839.95
		FEE SCHEDULE-LAB	34,990.59
		INJECTABLE DRUGS	21,329.60

TOTAL NUMBER OF CLAIMS 1,010

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,574.26	34.50	OTHER LAB	4,185.00	0.00
MED/SURG SUPPLY	34,519.33	316.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	642.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,180.00	2,999.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	179,718.00	11,018.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,981.00	802.00	FEE SCHEDULE LAB	334,304.00	25,022.00
EKG/ECG	21,650.00	0.00	MRI SERVICES	32,305.00	0.00
IV THERAPY	112,079.00	5,031.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,005.00	2,619.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,084.00	13,570.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,218.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,110.00	730.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,401.33	1,627.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,229.56	10,685.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,886.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	461.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	648.00	666.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,823.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	155.00	24.60
OTHER IMAGING SERVICE	10,959.00	92.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,052.00	657.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,168.00	4,000.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,899.00	907.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	465.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,384.00	3,496.00			

TOTAL ANCILLARY	1,250,446.48	87,762.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,250,446.48	87,762.81

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2218081004502	03/18/18 - 03/18/18	03/26/18	0.00	24.60	0.00	0.00	0.00
8004	9818124000015	04/19/18 - 04/19/18	05/14/18	155.00	0.00	0.00	0.00	0.00
TOTAL				155.00	24.60	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

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,729.59	ADJUSTMENTS	0.00
COVERED CHARGES	1,673.13	CONTRACTUAL ALLOW	1,192.34
NON-COVERD CHARGES	56.46	TOTAL MEDICAID LIAB	480.79
		LESS: COB	479.77
		LESS: COPAYMENT	1.02
		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

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	40.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235.00	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	1,204.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	208.00	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	26.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,673.13	56.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,673.13	56.46

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,880.97	ADJUSTMENTS	446.72
COVERED CHARGES	29,440.64	CONTRACTUAL ALLOW	26,576.50
NON-COVERD CHARGES	4,440.33	TOTAL MEDICAID LIAB	2,864.14
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	2,777.14
		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

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.62	6.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	244.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,026.00	326.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,365.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,315.00	907.00
EKG/ECG	465.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	960.00	74.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	14,111.00	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	2,838.21	3,052.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,440.64	4,440.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,440.64	4,440.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING HOSPITAL
163 E TOLLISON ST
BAXLEY,GA 31513-0120

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BACON COUNTY HOSPITAL
302 S WAYNE ST
ALMA,GA 31510-2922

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,533,403.10	ADJUSTMENTS	46,290.17
COVERED CHARGES	2,327,613.75	CONTRACTUAL ALLOW	1,607,998.42
NON-COVERD CHARGES	205,789.35	TOTAL MEDICAID LIAB	719,615.33
		LESS: COB	16,585.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	703,029.50

TOTAL NUMBER OF ADMISSIONS 136

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	405	0	262,941.40	7,782.20
ROUTINE NURSERY	47	0	30,059.80	1,729.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	452	0	293,001.20	9,511.70
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	68	0	58,098.20	22,708.80
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	58,098.20	22,708.80
TOTAL ACCOMODATIONS	520	0	351,099.40	32,220.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	476,516.53	41,851.06	OTHER LAB	8,613.70	0.00
MED/SURG SUPPLY	236,770.95	14,827.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	428,608.30	16,440.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,340.40	2,816.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,037.30	43,050.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,137.58	2,280.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	25,631.60	357.40	MRI SERVICES	23,860.20	0.00
IV THERAPY	4,341.60	5,321.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	147,696.40	9,194.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,919.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	183,420.60	22,970.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,176.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,222.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,279.50	958.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,257.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,890.72	751.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,647.60	545.80	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	69,792.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,502.00	600.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,481.60	10,906.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,280.20	407.80			
AUDIOLOGY	10,853.00	0.00			
CARDIOLOGY	4,458.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,868.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,787.40	288.20			

TOTAL ANCILLARY	1,976,514.35	173,568.85
TOTAL ACCOMODATIONS	351,099.40	32,220.50
TOTAL CHARGES	2,327,613.75	205,789.35

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,526.23	ADJUSTMENTS	0.00
COVERED CHARGES	7,526.13	CONTRACTUAL ALLOW	-737.73
NON-COVERD CHARGES	5,000.10	TOTAL MEDICAID LIAB	8,263.86
		LESS: COB	8,263.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,318.00	0.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,318.00	0.80
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	1,318.00	0.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,102.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,635.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	146.90	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	4,999.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,923.20	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	399.40	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,208.13	4,999.30
TOTAL ACCOMODATIONS	1,318.00	0.80
TOTAL CHARGES	7,526.13	5,000.10

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,072,452.53	ADJUSTMENTS	77,117.56
COVERED CHARGES	1,890,823.84	CONTRACTUAL ALLOW	1,399,669.15
NON-COVERD CHARGES	181,628.69	TOTAL MEDICAID LIAB	491,154.69
		LESS: COB	342.74
		LESS: COPAYMENT	1,251.00
		REIMBURSEMENT	489,560.95
		ALL OTHER	442,750.45
		FEE SCHEDULE-LAB	46,799.18
		INJECTABLE DRUGS	11.32
		TOTAL NUMBER OF CLAIMS	1,393

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,099.72	2,004.14	OTHER LAB	22,298.37	0.00
MED/SURG SUPPLY	90,896.70	880.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	495.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	146,916.70	3,689.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	273,347.90	42,556.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,315.60	3,654.30	FEE SCHEDULE LAB	489,779.80	28,534.50
EKG/ECG	26,749.40	1,270.80	MRI SERVICES	193,217.70	2,557.40
IV THERAPY	7,415.60	3,783.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,928.02	35,678.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,771.90	4,377.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,761.80	2,914.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	277,722.20	26,875.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,881.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,002.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	443.00	1,026.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,679.10	775.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	15,560.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,279.20	7,537.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	718.00	808.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,551.70	9,622.14			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,797.64	2,280.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,418.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,270.66	308.00			

TOTAL ANCILLARY	1,890,823.84	181,628.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,890,823.84	181,628.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,960.14	ADJUSTMENTS	0.00
COVERED CHARGES	12,376.64	CONTRACTUAL ALLOW	3,403.31
NON-COVERD CHARGES	4,583.50	TOTAL MEDICAID LIAB	8,973.33
		LESS: COB	8,961.33
		LESS: COPAYMENT	12.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	575.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,839.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203.00	203.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,400.00	1,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,623.80	378.80
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	1,958.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,252.80	1,252.80	AMBULANCE	0.00	0.00
GI SERVICES	1,414.30	903.90	CAST ROOM	0.00	0.00
EMERGENCY ROOM	392.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	718.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,376.64	4,583.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,376.64	4,583.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	158,153.86	ADJUSTMENTS	150.00
COVERED CHARGES	148,744.23	CONTRACTUAL ALLOW	139,698.23
NON-COVERD CHARGES	9,409.63	TOTAL MEDICAID LIAB	9,046.00
		LESS: COB	0.00
		LESS: COPAYMENT	354.00
		REIMBURSEMENT	8,692.00
		TOTAL NUMBER OF CLAIMS	181

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,541.44	107.63	OTHER LAB	1,269.10	0.00
MED/SURG SUPPLY	3,395.00	94.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,904.00	1,121.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,147.30	1,526.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,886.80	2,972.70
EKG/ECG	1,905.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,128.40	316.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,186.40	3,271.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	191.63	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,831.30	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	906.36	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	301.30	0.00			

TOTAL ANCILLARY	148,744.23	9,409.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	148,744.23	9,409.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,286.99	ADJUSTMENTS	5,089.42
COVERED CHARGES	45,437.30	CONTRACTUAL ALLOW	35,252.46
NON-COVERD CHARGES	3,849.69	TOTAL MEDICAID LIAB	10,184.84
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	10,169.84

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,091.33	20.16	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,373.80	249.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,036.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,143.40	52.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	61.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,063.37	2,866.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,926.60	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	12,305.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	600.50			
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	301.30	0.00			

TOTAL ANCILLARY	45,437.30	3,849.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,437.30	3,849.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	59,538.71	ADJUSTMENTS	0.00
COVERED CHARGES	59,538.71	CONTRACTUAL ALLOW	25,807.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	33,731.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,731.22

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	22	0	10,670.00	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	10,670.00	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	10,670.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,956.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,167.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,423.01	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,469.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,627.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	685.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	485.00	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	4,012.80	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	4,214.00	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	10,412.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	477.40	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,561.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,376.00	0.00			

TOTAL ANCILLARY	48,868.71	0.00
TOTAL ACCOMODATIONS	10,670.00	0.00
TOTAL CHARGES	59,538.71	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	552,874.82	ADJUSTMENTS	74,007.86
COVERED CHARGES	538,557.42	CONTRACTUAL ALLOW	234,413.06
NON-COVERD CHARGES	14,317.40	TOTAL MEDICAID LIAB	304,144.36
		LESS: COB	551.60
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	303,274.76
		ALL OTHER	268,361.30
		FEE SCHEDULE-LAB	27,314.51
		INJECTABLE DRUGS	7,598.95

TOTAL NUMBER OF CLAIMS 682

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,862.05	1,010.00	OTHER LAB	27,693.72	0.00
MED/SURG SUPPLY	14,209.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,502.85	506.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,129.30	805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,323.65	0.00	FEE SCHEDULE LAB	185,616.20	2,695.20
EKG/ECG	13,745.00	235.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,502.00	44.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	86.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,588.90	507.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,195.08	610.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,856.66	7,485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	76.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	605.00	343.20			
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	3,254.46	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,387.20	0.00			

TOTAL ANCILLARY	538,557.42	14,317.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	538,557.42	14,317.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,026.05	ADJUSTMENTS	0.00
COVERED CHARGES	2,888.45	CONTRACTUAL ALLOW	902.46
NON-COVERD CHARGES	137.60	TOTAL MEDICAID LIAB	1,985.99
		LESS: COB	1,985.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	297.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.05	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	699.85	27.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	298.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34.10	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	324.50	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	281.25	110.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	871.20	0.00			

TOTAL ANCILLARY	2,888.45	137.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,888.45	137.60

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,752.52	ADJUSTMENTS	97.00
COVERED CHARGES	41,996.32	CONTRACTUAL ALLOW	37,846.32
NON-COVERD CHARGES	756.20	TOTAL MEDICAID LIAB	4,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	3,979.00
		TOTAL NUMBER OF CLAIMS	83

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206.50	195.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	416.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,872.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,781.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,412.85	281.20
EKG/ECG	750.00	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	138.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,056.50	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	1,362.45	280.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,996.32	756.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,996.32	756.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 E PEACOCK ST
COCHRAN,GA 31014-7846

PROVIDER NUMBER
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,872.00	ADJUSTMENTS	0.00
COVERED CHARGES	178,657.00	CONTRACTUAL ALLOW	93,313.53
NON-COVERD CHARGES	6,215.00	TOTAL MEDICAID LIAB	85,343.47
		LESS: COB	1,156.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	84,187.41

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	32,358.00	5,514.00
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	50	0	32,358.00	5,514.00
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	50	0	32,358.00	5,514.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,748.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,103.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,556.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,098.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,198.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,146.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,926.00	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	19,197.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,309.00	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	2,204.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	866.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,444.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	701.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	146,299.00	701.00
TOTAL ACCOMODATIONS	32,358.00	5,514.00
TOTAL CHARGES	178,657.00	6,215.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,242,668.63	ADJUSTMENTS	50,112.27
COVERED CHARGES	1,198,040.60	CONTRACTUAL ALLOW	887,684.04
NON-COVERD CHARGES	44,628.03	TOTAL MEDICAID LIAB	310,356.56
		LESS: COB	1,393.13
		LESS: COPAYMENT	927.00
		REIMBURSEMENT	308,036.43
		ALL OTHER	267,739.00
		FEE SCHEDULE-LAB	38,280.81
		INJECTABLE DRUGS	2,016.62

TOTAL NUMBER OF CLAIMS 1,396

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,253.20	30.00	OTHER LAB	3,226.00	0.00
MED/SURG SUPPLY	12,420.00	627.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,708.00	1,952.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	192,527.00	17,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,012.00	3,752.03	FEE SCHEDULE LAB	334,685.00	7,837.00
EKG/ECG	9,064.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,467.00	136.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,849.00	1,306.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	311,342.00	3,936.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,537.40	726.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,749.00	5,167.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	152.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	924.00	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	NO CC/INVALID REV CODE	69.00	0.00
OTHER IMAGING SERVICE	17,392.00	168.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,820.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,920.00	435.00			

TOTAL ANCILLARY	1,198,040.60	44,628.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,198,040.60	44,628.03

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 10/01/17 THROUGH 09/30/18
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	2018277118679	09/27/18 - 09/27/18	10/08/18	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,081.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,863.00	CONTRACTUAL ALLOW	-1,208.82
NON-COVERD CHARGES	3,218.00	TOTAL MEDICAID LIAB	5,071.82
		LESS: COB	5,071.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	110.00	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	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,949.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	264.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,380.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,863.00	3,218.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,863.00	3,218.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,087.00	ADJUSTMENTS	1,707.00
COVERED CHARGES	40,515.00	CONTRACTUAL ALLOW	35,845.00
NON-COVERD CHARGES	3,572.00	TOTAL MEDICAID LIAB	4,670.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	4,568.00
		TOTAL NUMBER OF CLAIMS	83

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	433.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	268.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,088.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,218.00	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,334.00	334.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	101.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,153.00	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	932.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	722.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,515.00	3,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,515.00	3,572.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,776.00	ADJUSTMENTS	0.00
COVERED CHARGES	91,776.00	CONTRACTUAL ALLOW	77,187.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	14,579.67

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,757.00	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	4,019.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	91,776.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,776.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	278,684.75	ADJUSTMENTS	0.00
COVERED CHARGES	275,738.75	CONTRACTUAL ALLOW	167,982.83
NON-COVERD CHARGES	2,946.00	TOTAL MEDICAID LIAB	107,755.92
		LESS: COB	2,442.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	105,312.94

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	54	0	31,104.00	1,296.00
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	54	0	31,104.00	1,296.00
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	54	0	31,104.00	1,296.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,976.45	0.00	OTHER LAB	677.73	0.00
MED/SURG SUPPLY	12,647.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,603.50	0.00	EDUCATION & TRAINING	302.76	0.00
RADIOLOGY-DIAGNOSTIC	9,966.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,752.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,275.00	0.00	MRI SERVICES	1,326.51	0.00
IV THERAPY	10,986.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,812.77	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,499.59	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	17,391.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	256.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,014.56	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,752.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,047.12	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	1,120.00	0.00			

TOTAL ANCILLARY	244,634.75	1,650.00
TOTAL ACCOMODATIONS	31,104.00	1,296.00
TOTAL CHARGES	275,738.75	2,946.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,362,700.10	ADJUSTMENTS	45,175.16
COVERED CHARGES	1,188,877.87	CONTRACTUAL ALLOW	878,390.21
NON-COVERD CHARGES	173,822.23	TOTAL MEDICAID LIAB	310,487.66
		LESS: COB	1,460.59
		LESS: COPAYMENT	540.00
		REIMBURSEMENT	308,487.07
		ALL OTHER	282,088.94
		FEE SCHEDULE-LAB	21,071.25
		INJECTABLE DRUGS	5,326.88

TOTAL NUMBER OF CLAIMS 812

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,073.10	1,791.00	OTHER LAB	13,876.38	0.00
MED/SURG SUPPLY	17,680.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	579.45
RADIOLOGY-DIAGNOSTIC	74,153.23	6,164.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	100,742.85	37,865.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	143,482.25	25,591.10
EKG/ECG	23,625.36	2,025.00	MRI SERVICES	25,660.44	3,544.65
IV THERAPY	95,421.25	32,418.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,895.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,063.02	38,410.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,527.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,205.97	3,586.97	CAST ROOM	0.00	0.00
EMERGENCY ROOM	467,150.89	4,229.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,627.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,906.93	3,864.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,537.36	4,049.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	105.25
OTHER IMAGING SERVICE	39,096.69	1,550.31			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,876.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,745.20	2,698.08			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,529.63	3,697.59			

TOTAL ANCILLARY	1,188,877.87	173,822.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,188,877.87	173,822.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
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
4109	2218121000256	06/24/17 - 06/24/17	05/07/18	0.00	105.25	0.00	0.00	0.00
TOTAL				0.00	105.25	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

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	122,340.25	ADJUSTMENTS	108.88
COVERED CHARGES	116,217.38	CONTRACTUAL ALLOW	110,735.26
NON-COVERD CHARGES	6,122.87	TOTAL MEDICAID LIAB	5,482.12
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	5,305.12
		TOTAL NUMBER OF CLAIMS	98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,252.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	828.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,460.00	808.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,199.79	1,418.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,578.50	1,336.75
EKG/ECG	1,350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,294.55	159.51	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,430.56	450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,893.46	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	2,484.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	507.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	938.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	300.00			

TOTAL ANCILLARY	116,217.38	6,122.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	116,217.38	6,122.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 S LIBERTY ST
WAYNESBORO,GA 30830-9686

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/17 THROUGH 05/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	587,252.72	ADJUSTMENTS	0.00
COVERED CHARGES	570,729.72	CONTRACTUAL ALLOW	339,826.06
NON-COVERD CHARGES	16,523.00	TOTAL MEDICAID LIAB	230,903.66
		LESS: COB	9,501.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	221,402.63

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	80	0	79,474.00	16,523.00
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	79,474.00	16,523.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	15	0	30,165.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	30,165.00	0.00
TOTAL ACCOMODATIONS	95	0	109,639.00	16,523.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,837.09	0.00	OTHER LAB	2,030.00	0.00
MED/SURG SUPPLY	44,736.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	119,040.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,304.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,633.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	459.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,178.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,762.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,355.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,997.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,508.00	0.00	INJECTABLE DRUGS	67,416.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,576.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,215.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,608.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,516.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,909.00	0.00			

TOTAL ANCILLARY	461,090.72	0.00
TOTAL ACCOMODATIONS	109,639.00	16,523.00
TOTAL CHARGES	570,729.72	16,523.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,706,665.79	ADJUSTMENTS	72,309.73
COVERED CHARGES	2,504,635.68	CONTRACTUAL ALLOW	1,987,274.07
NON-COVERD CHARGES	202,030.11	TOTAL MEDICAID LIAB	517,361.61
		LESS: COB	473.40
		LESS: COPAYMENT	1,056.00
		REIMBURSEMENT	515,832.21
		ALL OTHER	460,158.39
		FEE SCHEDULE-LAB	52,310.75
		INJECTABLE DRUGS	3,363.07

TOTAL NUMBER OF CLAIMS 1,057

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,566.68	0.00	OTHER LAB	5,424.00	0.00
MED/SURG SUPPLY	281,187.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,260.00	2,749.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	349,652.00	56,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,973.00	4,120.02	FEE SCHEDULE LAB	533,571.94	32,101.11
EKG/ECG	30,163.00	3,383.00	MRI SERVICES	68,514.00	7,710.00
IV THERAPY	5,079.00	2,988.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	432,194.00	37,716.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,837.52	7,151.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	371,009.00	9,990.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	136,584.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	51,668.29	15,862.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,896.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	352.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,374.00
OTHER IMAGING SERVICE	40,807.00	1,574.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,152.00	1,788.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,641.00	8,622.00			

TOTAL ANCILLARY	2,504,635.68	202,030.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,504,635.68	202,030.11

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 01/01/18 THROUGH 12/31/18
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	2018177038984	06/20/18 - 06/20/18	07/02/18	0.00	3,687.00	0.00	0.00	0.00
615	2018177038984	06/20/18 - 06/20/18	07/02/18	0.00	3,687.00	0.00	0.00	0.00
TOTAL				0.00	7,374.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,066.63	ADJUSTMENTS	0.00
COVERED CHARGES	4,714.13	CONTRACTUAL ALLOW	298.67
NON-COVERD CHARGES	3,352.50	TOTAL MEDICAID LIAB	4,415.46
		LESS: COB	4,407.46
		LESS: COPAYMENT	8.00
		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

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,741.00	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	3,328.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	500.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	201.00	24.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,714.13	3,352.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,714.13	3,352.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,831.66	ADJUSTMENTS	1,682.00
COVERED CHARGES	78,781.66	CONTRACTUAL ALLOW	75,021.66
NON-COVERD CHARGES	4,050.00	TOTAL MEDICAID LIAB	3,760.00
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	3,637.00
		TOTAL NUMBER OF CLAIMS	64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,466.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,983.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,232.00	256.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,175.00	2,415.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	470.00	292.00	FEE SCHEDULE LAB	16,083.35	1,071.00
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	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	40,256.00	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	1,702.61	16.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	78,781.66	4,050.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,781.66	4,050.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR ST
METTER,GA 30439-3338

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,225,981.20	ADJUSTMENTS	249,226.78
COVERED CHARGES	21,910,733.20	CONTRACTUAL ALLOW	15,435,162.50
NON-COVERD CHARGES	315,248.00	TOTAL MEDICAID LIAB	6,475,570.70
		LESS: COB	71,435.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,404,134.99

TOTAL NUMBER OF ADMISSIONS 574

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,611	0	2,741,550.00	92,937.00
ROUTINE NURSERY	172	0	120,540.00	43,750.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,783	0	2,862,090.00	136,687.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	818	0	2,149,169.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	818	0	2,149,169.00	0.00
TOTAL ACCOMODATIONS	3,601	0	5,011,259.00	136,687.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,598,913.74	0.00	OTHER LAB	81,749.00	0.00
MED/SURG SUPPLY	395,507.29	2,490.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,471,209.92	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	709,853.00	0.00	OTHER THERAPEUTIC SVC	0.00	69,216.00
CT SCAN	1,106,584.00	27,301.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	232,977.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	67,349.00	0.00	MRI SERVICES	320,085.00	0.00
IV THERAPY	518,839.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,422,718.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	201,016.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,174,715.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	432,568.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	131,966.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	786,847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	283,161.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	114,193.00	0.00	INJECTABLE DRUGS	2,352,318.94	0.00
RADIOLOGY THERAPEUTIC	138,395.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	91,678.76	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	104,267.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	125,477.00	7,047.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	199,590.00	0.00
LITHOTRIPSY	36,730.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	119,948.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	289,651.00	23,342.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	85,532.00	49,165.00			
AUDIOLOGY	476.00	0.00			
CARDIOLOGY	165,497.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,776.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,886.00	0.00			

TOTAL ANCILLARY	16,899,474.20	178,561.00
TOTAL ACCOMODATIONS	5,011,259.00	136,687.00
TOTAL CHARGES	21,910,733.20	315,248.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,297.00	ADJUSTMENTS	0.00
COVERED CHARGES	154,842.00	CONTRACTUAL ALLOW	68,733.53
NON-COVERD CHARGES	5,455.00	TOTAL MEDICAID LIAB	86,108.47
		LESS: COB	86,108.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	25	0	26,250.00	800.00
ROUTINE NURSERY	10	0	9,135.00	4,655.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	35	0	35,385.00	5,455.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	7,060.00	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	2	0	7,060.00	0.00
TOTAL ACCOMODATIONS	37	0	42,445.00	5,455.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	910.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,573.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,945.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,823.00	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	436.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,117.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,304.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,875.00	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	10,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	296.00	0.00	INJECTABLE DRUGS	8,929.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,397.00	0.00
TOTAL ACCOMODATIONS	42,445.00	5,455.00
TOTAL CHARGES	154,842.00	5,455.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,979,190.98	ADJUSTMENTS	533,227.57
COVERED CHARGES	21,588,368.24	CONTRACTUAL ALLOW	18,054,165.32
NON-COVERD CHARGES	1,390,822.74	TOTAL MEDICAID LIAB	3,534,202.92
		LESS: COB	9,571.69
		LESS: COPAYMENT	9,997.03
		REIMBURSEMENT	3,514,634.20
		ALL OTHER	3,280,968.85
		FEE SCHEDULE-LAB	233,072.14
		INJECTABLE DRUGS	593.21

TOTAL NUMBER OF CLAIMS 7,866

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,003,075.71	1,463.69	OTHER LAB	168,028.00	0.00
MED/SURG SUPPLY	194,764.22	624.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	995.20
RADIOLOGY-DIAGNOSTIC	690,188.00	55,487.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,077,884.00	266,377.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	63,048.00	17,463.07	FEE SCHEDULE LAB	1,940,320.15	80,622.32
EKG/ECG	95,864.00	920.00	MRI SERVICES	312,508.00	27,903.00
IV THERAPY	1,897,143.00	58,595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,749,576.35	262,900.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,472.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	745,130.00	16,574.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	528,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	61,539.00	19,389.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,482,505.00	12,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	449,466.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,878.48	840.00
RADIOLOGY THERAPEUTIC	2,575,086.00	86,015.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,116.00	3,737.19	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,460.00	4,891.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,285.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,400.00	83.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	279,711.00	87,157.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	650,352.00	51,515.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	142,704.00	66,843.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,918.00	218,479.00			
AUDIOLOGY	0.00	6,876.00			
CARDIOLOGY	23,654.00	7,733.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,322.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	350,907.33	24,179.00			

TOTAL ANCILLARY	21,588,368.24	1,390,822.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,588,368.24	1,390,822.74

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	511,983.75	ADJUSTMENTS	0.00
COVERED CHARGES	338,507.50	CONTRACTUAL ALLOW	165,530.14
NON-COVERD CHARGES	173,476.25	TOTAL MEDICAID LIAB	172,977.36
		LESS: COB	172,880.63
		LESS: COPAYMENT	96.73
		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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,465.26	0.00	OTHER LAB	1,474.00	0.00
MED/SURG SUPPLY	8,063.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,719.00	3,276.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,854.00	17,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,331.00	1,451.00
EKG/ECG	1,840.00	0.00	MRI SERVICES	0.00	2,339.00
IV THERAPY	29,333.00	1,175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,353.75	49,816.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	206.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,159.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,353.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,488.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,480.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,315.49	59,275.00
RADIOLOGY THERAPEUTIC	74,009.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	511.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	345.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	472.00	21,812.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,289.00	3,092.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,926.00	5,305.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	730.00	450.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	480.00			

TOTAL ANCILLARY	338,507.50	173,476.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338,507.50	173,476.25

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	589,121.58	ADJUSTMENTS	1,765.02
COVERED CHARGES	565,812.58	CONTRACTUAL ALLOW	542,821.24
NON-COVERD CHARGES	23,309.00	TOTAL MEDICAID LIAB	22,991.34
		LESS: COB	0.00
		LESS: COPAYMENT	834.00
		REIMBURSEMENT	22,157.34

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,361.58	0.00	OTHER LAB	5,855.00	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	62,481.00	6,042.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,733.00	9,369.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,686.00	2,634.00
EKG/ECG	4,232.00	0.00	MRI SERVICES	10,768.00	2,339.00
IV THERAPY	82,629.00	127.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	559.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,914.00	412.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	288,704.00	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	62.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,828.00	2,386.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	565,812.58	23,309.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	565,812.58	23,309.00

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 HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,342.56	ADJUSTMENTS	0.00
COVERED CHARGES	6,641.56	CONTRACTUAL ALLOW	5,839.72
NON-COVERD CHARGES	701.00	TOTAL MEDICAID LIAB	801.84
		LESS: COB	801.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,249.00	88.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	413.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,413.00	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	113.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	613.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	345.00	0.00			

TOTAL ANCILLARY	6,641.56	701.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,641.56	701.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,198,822.78	ADJUSTMENTS	33,208.38
COVERED CHARGES	3,163,112.16	CONTRACTUAL ALLOW	2,824,853.13
NON-COVERD CHARGES	35,710.62	TOTAL MEDICAID LIAB	338,259.03
		LESS: COB	0.00
		LESS: COPAYMENT	247.82
		REIMBURSEMENT	338,011.21

TOTAL NUMBER OF CLAIMS 61

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,755,211.06	4.72	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,982.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,966.00	4,162.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,266.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,974.00	340.00
EKG/ECG	184.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,484.00	2,891.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,477.10	26,300.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,605.00	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	12,940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	66,902.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	98,114.00	0.00
LITHOTRIPSY	36,730.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	858.00	1,667.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,419.00	345.00			

TOTAL ANCILLARY	3,163,112.16	35,710.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,163,112.16	35,710.62

GEORGIA DEPARTMENT OF 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,085,327.13	ADJUSTMENTS	563,906.65
COVERED CHARGES	46,619,114.47	CONTRACTUAL ALLOW	38,884,165.98
NON-COVERD CHARGES	466,212.66	TOTAL MEDICAID LIAB	7,734,948.49
		LESS: COB	60,184.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,674,764.39

TOTAL NUMBER OF ADMISSIONS 787

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,187	0	4,302,344.00	250,307.00
ROUTINE NURSERY	97	0	83,601.00	482.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,284	0	4,385,945.00	250,789.00
SPECIAL CARE SERVICES				
CCU	151	0	379,614.00	0.00
ICU	823	0	2,264,345.00	0.00
NICU	11	0	37,642.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	985	0	2,681,601.00	0.00
TOTAL ACCOMODATIONS	4,269	0	7,067,546.00	250,789.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,330,019.99	7,620.75	OTHER LAB	236,718.80	1,908.80
MED/SURG SUPPLY	3,319,836.38	7,378.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,457,848.60	1,728.70	EDUCATION & TRAINING	800.00	0.00
RADIOLOGY-DIAGNOSTIC	840,843.64	599.16	OTHER THERAPEUTIC SVC	0.00	342.00
CT SCAN	2,406,272.50	26,827.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	268,778.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	273,160.50	0.00	MRI SERVICES	500,473.50	4,823.80
IV THERAPY	234,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,545,751.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	200,834.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,298,586.60	2,558.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924,886.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	140,035.00	1,970.60	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,903,385.21	2,075.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	207,312.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	249,683.19	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	36,552.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	66,101.13	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	150,908.53	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	504,711.60	9,124.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,689.70	691.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	686,747.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	192,681.97	6,615.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	404,894.90	140,302.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	270,580.50	856.00			
AUDIOLOGY	1,511.20	0.00			
CARDIOLOGY	1,573,264.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,023.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,536.58	0.00			

TOTAL ANCILLARY	39,551,568.47	215,423.66
TOTAL ACCOMODATIONS	7,067,546.00	250,789.00
TOTAL CHARGES	46,619,114.47	466,212.66

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,059.98	ADJUSTMENTS	0.00
COVERED CHARGES	38,059.98	CONTRACTUAL ALLOW	11,752.47
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	26,307.51
		LESS: COB	26,307.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4	0	5,392.00	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	5,392.00	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	5,392.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,635.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	857.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,272.00	0.00	EDUCATION & TRAINING	160.00	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	8,532.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,624.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,868.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,909.00	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	1,110.00	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	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	859.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	730.00	0.00			

TOTAL ANCILLARY	32,667.98	0.00
TOTAL ACCOMODATIONS	5,392.00	0.00
TOTAL CHARGES	38,059.98	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,509,079.62	ADJUSTMENTS	465,355.13
COVERED CHARGES	22,633,109.30	CONTRACTUAL ALLOW	20,035,964.39
NON-COVERD CHARGES	1,875,970.32	TOTAL MEDICAID LIAB	2,597,144.91
		LESS: COB	3,036.26
		LESS: COPAYMENT	5,079.00
		REIMBURSEMENT	2,589,029.65
		ALL OTHER	2,320,740.10
		FEE SCHEDULE-LAB	208,384.92
		INJECTABLE DRUGS	59,904.63
		TOTAL NUMBER OF CLAIMS	5,325

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621,783.68	0.00	OTHER LAB	309,738.60	0.00
MED/SURG SUPPLY	927,777.08	1,090.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,158,368.40	34,220.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,660,794.50	492,070.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,669.30	35,910.85	FEE SCHEDULE LAB	3,465,759.72	94,230.38
EKG/ECG	393,363.50	2,150.00	MRI SERVICES	285,258.00	37,229.70
IV THERAPY	857,515.40	37,140.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,243,594.54	254,172.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	366,156.30	22,145.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	640,573.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	38,254.10	8,383.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,614,758.80	7,434.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,264.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,372.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	952,142.96	433,030.99
RADIOLOGY THERAPEUTIC	45,983.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	31,741.20	22,894.90	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,463.70	12,198.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,269.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,415.70	8,684.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,732.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	503,195.02	119,323.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	101,285.10	32,074.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	250,055.20	59,798.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	450,681.40	58,041.00			
AMBULATORY SURGERY	8,000.20	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	584,848.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	619,933.88	94,104.90			

TOTAL ANCILLARY	22,633,109.30	1,875,970.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,633,109.30	1,875,970.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,822.96	ADJUSTMENTS	0.00
COVERED CHARGES	92,393.95	CONTRACTUAL ALLOW	65,774.38
NON-COVERD CHARGES	11,429.01	TOTAL MEDICAID LIAB	26,619.57
		LESS: COB	26,612.00
		LESS: COPAYMENT	7.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,359.39	0.00	OTHER LAB	1,755.60	0.00
MED/SURG SUPPLY	3,379.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,814.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,466.70	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,198.62	1,295.17
EKG/ECG	409.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,980.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,841.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,704.10	445.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,069.00	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	929.94	160.14
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	805.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,005.40	3,178.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,318.40	1,496.00			

TOTAL ANCILLARY	92,393.95	11,429.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	92,393.95	11,429.01

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,316,523.96	ADJUSTMENTS	323.64
COVERED CHARGES	1,205,583.93	CONTRACTUAL ALLOW	1,174,649.11
NON-COVERD CHARGES	110,940.03	TOTAL MEDICAID LIAB	30,934.82
		LESS: COB	0.00
		LESS: COPAYMENT	1,107.00
		REIMBURSEMENT	29,827.82
		TOTAL NUMBER OF CLAIMS	553

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,236.89	0.00	OTHER LAB	20,651.60	0.00
MED/SURG SUPPLY	6,051.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,221.56	6,830.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,557.80	82,654.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	206,664.53	3,515.75
EKG/ECG	20,681.00	0.00	MRI SERVICES	3,791.00	5,294.40
IV THERAPY	48,500.30	901.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,248.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	646,606.40	518.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39,029.62	2,184.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,862.10	9,040.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,370.80	0.00			

TOTAL ANCILLARY	1,205,583.93	110,940.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,205,583.93	110,940.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,831.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,083.20	CONTRACTUAL ALLOW	5,390.62
NON-COVERD CHARGES	2,748.30	TOTAL MEDICAID LIAB	1,692.58
		LESS: COB	1,692.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.00	0.00	OTHER LAB	1,755.60	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	669.00	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	1,855.00	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	2,465.90	919.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,002.70	1,159.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,083.20	2,748.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,083.20	2,748.30

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,355,330.30	ADJUSTMENTS	10,875.20
COVERED CHARGES	1,298,043.29	CONTRACTUAL ALLOW	1,167,468.89
NON-COVERD CHARGES	57,287.01	TOTAL MEDICAID LIAB	130,574.40
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	130,445.40

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,962.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	227,487.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,348.07	11,057.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,426.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,209.19	126.47
EKG/ECG	2,457.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,196.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	440,881.43	12,104.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,154.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,546.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,989.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100,923.49	33,696.07
RADIOLOGY THERAPEUTIC	7,284.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	302.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	114,508.67	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	153,273.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,346.80	0.00			

TOTAL ANCILLARY	1,298,043.29	57,287.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,298,043.29	57,287.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	326,209,456.27	ADJUSTMENTS	36,452,534.01
COVERED CHARGES	319,781,868.22	CONTRACTUAL ALLOW	225,328,043.75
NON-COVERD CHARGES	6,427,588.05	TOTAL MEDICAID LIAB	94,453,824.47
		LESS: COB	472,843.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	93,980,980.70

TOTAL NUMBER OF ADMISSIONS 2,806

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15,588	0	24,439,552.75	3,398,175.75
ROUTINE NURSERY	1,908	0	9,539,694.00	14,060.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17,496	0	33,979,246.75	3,412,236.25
SPECIAL CARE SERVICES				
CCU	2,839	0	13,334,326.50	0.00
ICU	0	0	0.00	0.00
NICU	341	0	2,317,024.00	0.00
PED ICU	4,193	0	19,483,424.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,373	0	35,134,774.50	0.00
TOTAL ACCOMODATIONS	24,869	0	69,114,021.25	3,412,236.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,660,778.60	193,919.75	OTHER LAB	1,174,592.00	0.00
MED/SURG SUPPLY	17,309,423.00	285,381.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,653,467.60	860,846.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,950,780.50	4,827.00	OTHER THERAPEUTIC SVC	58,381.50	169,119.50
CT SCAN	1,868,708.00	90,129.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,530,448.00	7,504.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	446,709.50	350.50	MRI SERVICES	1,714,278.50	0.00
IV THERAPY	41,829.00	6,281.50	PROFESSIONAL FEES	0.00	4,635.00
OPERATING ROOM	38,748,697.00	51,512.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,001,303.91	232,609.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,017,954.00	26,991.00	AMBULANCE	0.00	0.00
GI SERVICES	14,441.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,594,031.36	34,674.64	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	979,017.50	1,333.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,013,399.18	0.00	INJECTABLE DRUGS	12,350.00	0.00
RADIOLOGY THERAPEUTIC	218,608.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,110,447.00	3,584.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	679,702.00	3,961.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	122,551.00	194,198.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,117.00	47,386.00	TRAUMA RESPONSE	0.00	67,976.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,407,081.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	921,326.50	129,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,907,248.00	186,126.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,378.50	8,417.00			
AUDIOLOGY	40,884.00	111.00			
CARDIOLOGY	6,883,230.50	7,747.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,674,329.00	5,774.00			
ORGAN ACQUISITION	4,386,781.50	16,351.00			
TREATMENT/OBSERV. RM	393,572.50	374,170.00			

TOTAL ANCILLARY	250,667,846.97	3,015,351.80
TOTAL ACCOMODATIONS	69,114,021.25	3,412,236.25
TOTAL CHARGES	319,781,868.22	6,427,588.05

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,460,698.65	ADJUSTMENTS	0.00
COVERED CHARGES	5,406,551.65	CONTRACTUAL ALLOW	2,805,066.04
NON-COVERD CHARGES	54,147.00	TOTAL MEDICAID LIAB	2,601,485.61
		LESS: COB	2,601,485.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	177	0	280,231.00	44,103.50
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	177	0	280,231.00	44,103.50
SPECIAL CARE SERVICES				
CCU	101	0	470,740.50	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	28	0	132,756.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	129	0	603,496.50	0.00
TOTAL ACCOMODATIONS	306	0	883,727.50	44,103.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	601,919.75	0.00	OTHER LAB	14,961.00	0.00
MED/SURG SUPPLY	407,833.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	745,969.07	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	81,371.50	0.00	OTHER THERAPEUTIC SVC	0.00	2,612.00
CT SCAN	13,012.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,035.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,570.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.50	0.00	PROFESSIONAL FEES	0.00	7,240.50
OPERATING ROOM	1,050,451.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	369,784.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	340,970.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,426.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,581.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	24,897.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,505.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,894.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,855.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	417,204.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,842.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,614.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	229.50	0.00			
CARDIOLOGY	113,699.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,296.00	0.00			
ORGAN ACQUISITION	142,640.50	0.00			
TREATMENT/OBSERV. RM	2,867.50	0.00			

TOTAL ANCILLARY	4,522,824.15	10,043.50
TOTAL ACCOMODATIONS	883,727.50	44,103.50
TOTAL CHARGES	5,406,551.65	54,147.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,308,323.43	ADJUSTMENTS	4,894,899.21
COVERED CHARGES	72,283,233.77	CONTRACTUAL ALLOW	56,269,830.91
NON-COVERD CHARGES	8,025,089.66	TOTAL MEDICAID LIAB	16,013,402.86
		LESS: COB	29,439.24
		LESS: COPAYMENT	190.67
		REIMBURSEMENT	15,983,772.95
		ALL OTHER	12,185,258.90
		FEE SCHEDULE-LAB	853,691.15
		INJECTABLE DRUGS	2,944,822.90

TOTAL NUMBER OF CLAIMS 18,656

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,606,843.00	9,543.50
MED/SURG SUPPLY	4,057,446.26	2,221.06
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,602,126.50	46,952.00
CT SCAN	1,703,035.50	103,310.50
PHYSICAL THERAPY	21,440.50	34,524.50
EKG/ECG	141,863.50	11,324.50
IV THERAPY	1,480,508.50	42,675.00
OPERATING ROOM	9,161,139.25	842,280.75
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	923,821.87	99,936.17
ANESTHESIA	5,182,396.50	0.00
GI SERVICES	7,851.50	0.00
EMERGENCY ROOM	6,196,163.50	68,753.00
RECOVERY ROOM	1,499,229.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	431,178.00	6,720.00
OCCUPATIONAL THERAPY	5,768.00	10,655.00
SPEECH PATHOLOGY	439,856.50	28,396.50
RENAL DIALYSIS	0.00	2,663.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,183,570.50	242,264.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	957,295.00	152,194.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,157,437.00	5,065.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	345,933.00	48,102.56
AUDIOLOGY	151,037.00	3,811.50
CARDIOLOGY	1,578,150.00	514,440.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,945,812.50	1,579.50
ORGAN ACQUISITION	0.00	31,053.00
TREATMENT/OBSERV. RM	1,702,425.50	866,217.50
OTHER LAB	771,437.50	6,154.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	9,156.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,217,353.10	2,461,012.92
MRI SERVICES	3,826,823.50	306,477.50
PROFESSIONAL FEES	0.00	2,533.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,669,646.70	1,878,643.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	105,441.00
IMPL DEV CHARGE PATIENTS	315,644.59	80,988.70
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	72,283,233.77	8,025,089.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,283,233.77	8,025,089.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
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	5918163000137	05/11/18 - 05/12/18	06/18/18	0.00	0.00	0.00	0.00	0.00
-1	5918163000137	05/11/18 - 05/12/18	06/18/18	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,145,518.63	ADJUSTMENTS	0.00
COVERED CHARGES	2,359,588.90	CONTRACTUAL ALLOW	671,649.93
NON-COVERD CHARGES	785,929.73	TOTAL MEDICAID LIAB	1,687,938.97
		LESS: COB	1,687,926.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 474

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,722.50	300.00	OTHER LAB	16,601.50	628.00
MED/SURG SUPPLY	193,887.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,500.00	2,560.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,312.50	44,371.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,032.00	1,920.00	FEE SCHEDULE LAB	409,263.87	64,998.50
EKG/ECG	3,735.00	701.00	MRI SERVICES	144,940.00	97,042.50
IV THERAPY	4,704.50	391.50	PROFESSIONAL FEES	0.00	1,118.00
OPERATING ROOM	395,596.00	191,958.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,951.52	3,077.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	353,236.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,439.50	4,499.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	176,269.25	89,536.00
RADIOLOGY THERAPEUTIC	79,545.50	640.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,920.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,331.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,415.50	10,239.00	TRAUMA RESPONSE	0.00	2,576.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,617.73	81,472.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,397.50	16,511.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,947.50	14,685.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,722.00	382.00			
AUDIOLOGY	2,594.50	331.50			
CARDIOLOGY	47,746.00	130,691.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,275.50	0.00			
ORGAN ACQUISITION	0.00	8,931.00			
TREATMENT/OBSERV. RM	45,885.50	15,035.00			

TOTAL ANCILLARY	2,359,588.90	785,929.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,359,588.90	785,929.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,051,390.22	ADJUSTMENTS	20,180.75
COVERED CHARGES	997,173.47	CONTRACTUAL ALLOW	943,570.84
NON-COVERD CHARGES	54,216.75	TOTAL MEDICAID LIAB	53,602.63
		LESS: COB	6.26
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	53,590.37

TOTAL NUMBER OF CLAIMS 866

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,171.50	0.00	OTHER LAB	4,159.00	0.00
MED/SURG SUPPLY	25,306.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,253.00	7,567.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,078.50	4,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	181,192.94	30,844.50
EKG/ECG	4,206.00	0.00	MRI SERVICES	2,509.50	2,584.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	297.00
OPERATING ROOM	1,835.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	766.00	396.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,180.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	639,771.50	2,887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,357.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,709.50	2,783.25
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	1,184.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,749.50	1,387.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,301.00	1,281.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,442.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	997,173.47	54,216.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	997,173.47	54,216.75

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,510.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,092.50	CONTRACTUAL ALLOW	9,321.69
NON-COVERD CHARGES	1,417.50	TOTAL MEDICAID LIAB	9,770.81
		LESS: COB	9,770.81
		LESS: COPAYMENT	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

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	257.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,539.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,319.00	0.00
EKG/ECG	701.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	559.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,685.50	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	172.50	165.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,387.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,092.50	1,417.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,092.50	1,417.50

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 AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,948,253.18	ADJUSTMENTS	570,177.40
COVERED CHARGES	19,885,087.59	CONTRACTUAL ALLOW	16,479,173.58
NON-COVERD CHARGES	3,063,165.59	TOTAL MEDICAID LIAB	3,405,914.01
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	3,405,908.01

TOTAL NUMBER OF CLAIMS 380

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,040.25	0.00	OTHER LAB	2,894.00	0.00
MED/SURG SUPPLY	3,100,754.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335,820.50	292,833.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,951.00	3,419.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,144.00	FEE SCHEDULE LAB	932,307.66	291,410.50
EKG/ECG	3,735.00	14,249.50	MRI SERVICES	52,199.00	33,262.00
IV THERAPY	215,465.00	2,765.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,146,269.00	853,433.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,766.43	11,304.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,328,269.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,360.00	1,010.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	257,187.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,368,591.00	95,833.75
RADIOLOGY THERAPEUTIC	25,619.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,192.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,331.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,092.00	5,702.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,303,552.74	225,063.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,727.00	9,830.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,495.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,014.00	455.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,272,047.50	1,126,348.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,395.50	0.00			
ORGAN ACQUISITION	0.00	8,931.00			
TREATMENT/OBSERV. RM	221,534.00	77,645.50			

TOTAL ANCILLARY	19,885,087.59	3,063,165.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,885,087.59	3,063,165.59

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	729,634.33	ADJUSTMENTS	0.00
COVERED CHARGES	637,596.08	CONTRACTUAL ALLOW	28,112.45
NON-COVERD CHARGES	92,038.25	TOTAL MEDICAID LIAB	609,483.63
		LESS: COB	609,483.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,013.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49,291.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,665.00	35,966.50	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	28,121.00	9,532.50
EKG/ECG	0.00	701.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	804.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,263.50	19,961.50	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	31,269.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,220.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,292.25	7,794.75
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	3,387.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500.00	2,392.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,572.00	14,886.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	637,596.08	92,038.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	637,596.08	92,038.25

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,927,255.38	ADJUSTMENTS	723,740.81
COVERED CHARGES	52,542,469.38	CONTRACTUAL ALLOW	45,670,456.11
NON-COVERD CHARGES	384,786.00	TOTAL MEDICAID LIAB	6,872,013.27
		LESS: COB	7,839.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,864,173.29

TOTAL NUMBER OF ADMISSIONS 739

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,974	0	3,614,340.00	216,195.00
ROUTINE NURSERY	136	0	252,875.00	20,660.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,110	0	3,867,215.00	236,855.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,424	0	4,971,080.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,424	0	4,971,080.00	0.00
TOTAL ACCOMODATIONS	3,534	0	8,838,295.00	236,855.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,325,646.83	0.00	OTHER LAB	266,502.00	0.00
MED/SURG SUPPLY	1,351,596.25	3,051.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,810,621.00	840.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938,932.25	0.00	OTHER THERAPEUTIC SVC	0.00	4,203.00
CT SCAN	3,670,004.00	35,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	656,266.35	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	726,933.00	0.00	MRI SERVICES	790,716.00	0.00
IV THERAPY	103,173.00	791.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,883,413.00	14,462.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	466,388.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,270,609.40	3,648.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,210,157.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	182,491.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,796,856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	331,113.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	360,329.00	0.00	INJECTABLE DRUGS	6,228,254.81	0.00
RADIOLOGY THERAPEUTIC	68,101.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	571,497.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	123,833.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	179,959.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,038.00	338.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	378,575.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	261,034.00	30,360.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	134,595.00	43,417.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	401,216.00	0.00			
AUDIOLOGY	0.00	11,016.00			
CARDIOLOGY	3,120,369.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,564.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	76,390.00	0.00			

TOTAL ANCILLARY	43,704,174.38	147,931.00
TOTAL ACCOMODATIONS	8,838,295.00	236,855.00
TOTAL CHARGES	52,542,469.38	384,786.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	178,560.51	ADJUSTMENTS	0.00
COVERED CHARGES	175,897.51	CONTRACTUAL ALLOW	135,010.02
NON-COVERD CHARGES	2,663.00	TOTAL MEDICAID LIAB	40,887.49
		LESS: COB	40,887.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	16	0	29,460.00	1,630.00
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	29,460.00	1,630.00
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	29,460.00	1,630.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,324.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,911.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,817.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	587.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,133.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,185.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,846.00	0.00	MRI SERVICES	5,899.00	0.00
IV THERAPY	348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,853.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,593.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,251.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,366.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,490.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,356.00	0.00	INJECTABLE DRUGS	11,780.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,186.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,244.00	1,033.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	146,437.51	1,033.00
TOTAL ACCOMODATIONS	29,460.00	1,630.00
TOTAL CHARGES	175,897.51	2,663.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,690,423.68	ADJUSTMENTS	166,274.01
COVERED CHARGES	27,213,381.72	CONTRACTUAL ALLOW	25,528,028.28
NON-COVERD CHARGES	3,477,041.96	TOTAL MEDICAID LIAB	1,685,353.44
		LESS: COB	1,861.14
		LESS: COPAYMENT	3,141.00
		REIMBURSEMENT	1,680,351.30
		ALL OTHER	1,461,203.72
		FEE SCHEDULE-LAB	182,332.56
		INJECTABLE DRUGS	36,815.02

TOTAL NUMBER OF CLAIMS 4,267

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	474,088.31	188,011.47	OTHER LAB	195,194.00	0.00
MED/SURG SUPPLY	466,784.75	47,293.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,233,616.25	246,028.00	OTHER THERAPEUTIC SVC	0.00	280.00
CT SCAN	4,624,468.00	676,902.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	30,310.00	FEE SCHEDULE LAB	6,469,653.00	597,903.00
EKG/ECG	819,700.00	3,692.00	MRI SERVICES	323,621.00	65,604.00
IV THERAPY	619,996.00	50,332.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,606,104.21	365,469.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,815.00	1,225.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,490.00	402.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	247,667.50	91,310.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,148,046.00	40,002.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	393,015.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	421,814.50	343,081.20
RADIOLOGY THERAPEUTIC	514,692.00	216,020.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	29,221.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,487.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,404.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,535.00	6,321.00	TRAUMA RESPONSE	0.00	9,500.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	138,725.00	20,123.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	693,337.00	85,600.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,646.00	6,198.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	511,705.00	125,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	685,837.00	191,174.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,396.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	362,048.20	32,968.00			

TOTAL ANCILLARY	27,213,381.72	3,477,041.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,213,381.72	3,477,041.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	317,672.75	ADJUSTMENTS	0.00
COVERED CHARGES	217,919.50	CONTRACTUAL ALLOW	159,231.30
NON-COVERD CHARGES	99,753.25	TOTAL MEDICAID LIAB	58,688.20
		LESS: COB	58,613.14
		LESS: COPAYMENT	75.06
		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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,377.75	2,428.75	OTHER LAB	1,522.00	0.00
MED/SURG SUPPLY	9,204.25	167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,168.00	4,499.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,271.00	27,946.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,330.00	2,627.00
EKG/ECG	7,384.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,408.00	209.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,614.00	45,589.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	886.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,131.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,015.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,311.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	687.50	645.50
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	1,058.00	240.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,813.00	1,633.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	13,769.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,115.00	0.00			

TOTAL ANCILLARY	217,919.50	99,753.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,919.50	99,753.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,923,474.00	ADJUSTMENTS	6,245.91
COVERED CHARGES	1,740,803.25	CONTRACTUAL ALLOW	1,714,634.29
NON-COVERD CHARGES	182,670.75	TOTAL MEDICAID LIAB	26,168.96
		LESS: COB	0.00
		LESS: COPAYMENT	837.00
		REIMBURSEMENT	25,331.96
		TOTAL NUMBER OF CLAIMS	445

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,408.75	15,807.50	OTHER LAB	7,376.00	0.00
MED/SURG SUPPLY	3,500.00	166.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,134.50	19,824.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	301,630.00	83,145.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	526,463.00	14,739.00
EKG/ECG	41,535.00	0.00	MRI SERVICES	8,739.00	5,899.00
IV THERAPY	41,819.00	2,090.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	936.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	646,513.00	2,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,544.00	17,621.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,469.00	17,351.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,016.00	1,033.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,463.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	1,740,803.25	182,670.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,740,803.25	182,670.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,046.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,896.00	CONTRACTUAL ALLOW	13,068.81
NON-COVERD CHARGES	1,150.00	TOTAL MEDICAID LIAB	6,827.19
		LESS: COB	6,821.19
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	667.00	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	781.00	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	9,410.00	1,035.00
EKG/ECG	1,846.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	419.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,773.00	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	115.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,896.00	1,150.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,896.00	1,150.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	999,600.25	ADJUSTMENTS	0.00
COVERED CHARGES	881,761.25	CONTRACTUAL ALLOW	832,795.85
NON-COVERD CHARGES	117,839.00	TOTAL MEDICAID LIAB	48,965.40
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	48,926.40

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,724.53	2,440.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56,685.00	8,193.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,913.00	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	24,494.00	377.00
EKG/ECG	10,153.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	264,845.75	91,937.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	429.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,115.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,369.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,307.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,225.25	725.75
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	64,601.00	6,876.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	288,601.00	7,290.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,298.72	0.00			

TOTAL ANCILLARY	881,761.25	117,839.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	881,761.25	117,839.00

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

CARTERSVILLE MEDICAL CENTER
960 JOE FRANK HARRIS PKWY SE
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1605

PROVIDER NUMBER
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	187,793,713.35	ADJUSTMENTS	13,744,397.00
COVERED CHARGES	181,898,105.74	CONTRACTUAL ALLOW	127,091,149.03
NON-COVERD CHARGES	5,895,607.61	TOTAL MEDICAID LIAB	54,806,956.71
		LESS: COB	614,548.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	54,192,408.45

TOTAL NUMBER OF ADMISSIONS 2,679

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,971	0	18,915,529.00	4,648,961.00
ROUTINE NURSERY	1,361	0	5,803,790.50	40,506.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,332	0	24,719,319.50	4,689,467.50
SPECIAL CARE SERVICES				
CCU	7	0	32,203.50	0.00
ICU	0	0	0.00	0.00
NICU	426	0	2,891,772.00	0.00
PED ICU	4,840	0	22,556,096.00	23,002.50
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,273	0	25,480,071.50	23,002.50
TOTAL ACCOMODATIONS	18,605	0	50,199,391.00	4,712,470.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,270,128.50	62,980.50	OTHER LAB	375,536.00	3,615.00
MED/SURG SUPPLY	8,483,006.84	38,622.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,309,798.26	44,601.01	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,909,742.00	609.00	OTHER THERAPEUTIC SVC	32,735.50	160,485.00
CT SCAN	2,163,085.50	1,638.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	945,070.00	2,464.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	96,701.00	0.00	MRI SERVICES	1,769,709.50	0.00
IV THERAPY	91,800.50	3,578.50	PROFESSIONAL FEES	0.00	16,022.00
OPERATING ROOM	13,262,330.50	3,450.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,446,516.83	169,420.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,899,558.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,151.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,593,867.00	18,869.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	611,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,003,072.50	0.00	INJECTABLE DRUGS	1,235.00	0.00
RADIOLOGY THERAPEUTIC	192,211.00	889.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	565,240.00	448.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	462,969.00	2,495.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,172.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	422.00	41,174.00	TRAUMA RESPONSE	0.00	46,180.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,852,247.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	391,385.00	13,544.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,408,214.50	35,189.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	260,858.00	9,741.00			
AUDIOLOGY	92,107.00	0.00			
CARDIOLOGY	1,019,405.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,682,056.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	488,713.50	486,949.50			

TOTAL ANCILLARY	131,698,714.74	1,183,137.61
TOTAL ACCOMODATIONS	50,199,391.00	4,712,470.00
TOTAL CHARGES	181,898,105.74	5,895,607.61

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,955,262.60	ADJUSTMENTS	0.00
COVERED CHARGES	4,823,465.10	CONTRACTUAL ALLOW	1,998,292.58
NON-COVERD CHARGES	131,797.50	TOTAL MEDICAID LIAB	2,825,172.52
		LESS: COB	2,825,172.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 46

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	201	0	318,173.50	113,897.50
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	201	0	318,173.50	113,897.50
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	230	0	1,071,912.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	230	0	1,071,912.00	0.00
TOTAL ACCOMODATIONS	431	0	1,390,085.50	113,897.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	622,040.00	0.00	OTHER LAB	11,017.50	0.00
MED/SURG SUPPLY	214,170.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	318,029.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,039.50	0.00	OTHER THERAPEUTIC SVC	0.00	4,312.50
CT SCAN	45,880.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,356.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,034.00	0.00	MRI SERVICES	105,632.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	13,086.50
OPERATING ROOM	461,229.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	811,415.83	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	195,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,639.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	53,390.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,125.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,328.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	220,584.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,481.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,978.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	331.50	0.00			
CARDIOLOGY	14,434.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	165,550.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,450.00	310.00			

TOTAL ANCILLARY	3,433,379.60	17,900.00
TOTAL ACCOMODATIONS	1,390,085.50	113,897.50
TOTAL CHARGES	4,823,465.10	131,797.50

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 01/01/18 THROUGH 12/31/18
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
932	2019155078811	10/11/18 - 11/06/18	06/10/19	0.00	0.00	0.00	267,198.90	0.00
TOTAL				0.00	0.00	0.00	267,198.90	0.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	66,759,639.83	ADJUSTMENTS	2,272,115.29
COVERED CHARGES	59,825,067.04	CONTRACTUAL ALLOW	45,305,094.87
NON-COVERD CHARGES	6,934,572.79	TOTAL MEDICAID LIAB	14,519,972.17
		LESS: COB	46,883.89
		LESS: COPAYMENT	477.07
		REIMBURSEMENT	14,472,611.21
		ALL OTHER	12,937,366.43
		FEE SCHEDULE-LAB	597,094.64
		INJECTABLE DRUGS	938,150.14

TOTAL NUMBER OF CLAIMS 23,240

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,156,297.75	5,436.75	OTHER LAB	431,428.50	4,595.00
MED/SURG SUPPLY	3,316,213.98	35,207.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,874,134.00	26,609.50	OTHER THERAPEUTIC SVC	0.00	11,137.00
CT SCAN	1,853,120.50	238,158.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,876,951.50	64,915.00	FEE SCHEDULE LAB	11,233,371.96	958,269.00
EKG/ECG	38,434.00	229.50	MRI SERVICES	4,656,111.00	286,241.00
IV THERAPY	1,316,107.50	45,030.00	PROFESSIONAL FEES	0.00	10,722.50
OPERATING ROOM	6,463,243.50	742,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	421,681.91	96,795.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,908,423.00	12,205.50	AMBULANCE	0.00	0.00
GI SERVICES	142,661.50	17,252.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,416,421.50	132,847.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	769,178.00	1,740.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,246,361.00	2,338,220.25
RADIOLOGY THERAPEUTIC	623,253.50	13,288.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	776,529.03	51,138.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	808,729.50	104,996.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,118,919.00	304,136.50	TRAUMA RESPONSE	0.00	57,818.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	247,792.16	242,526.18
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	772,141.50	44,234.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,151,381.00	9,736.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	161,315.00	16,226.50			
AUDIOLOGY	346,828.25	24,827.00			
CARDIOLOGY	109,990.50	52,162.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,119,535.00	3,383.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,468,511.50	982,302.00			

TOTAL ANCILLARY	59,825,067.04	6,934,572.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,825,067.04	6,934,572.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,166,143.19	ADJUSTMENTS	0.00
COVERED CHARGES	1,625,595.88	CONTRACTUAL ALLOW	506,415.02
NON-COVERD CHARGES	540,547.31	TOTAL MEDICAID LIAB	1,119,180.86
		LESS: COB	1,119,174.86
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 528

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,490.75	0.00	OTHER LAB	2,134.00	0.00
MED/SURG SUPPLY	145,288.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,120.50	673.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,963.00	12,506.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,055.00	336.00	FEE SCHEDULE LAB	247,194.37	12,730.50
EKG/ECG	0.00	0.00	MRI SERVICES	106,067.50	118,853.50
IV THERAPY	6,080.00	2,973.00	PROFESSIONAL FEES	0.00	4,782.50
OPERATING ROOM	233,346.50	150,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,820.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	201,401.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,031.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,385.50	382.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,472.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140,116.00	121,507.25
RADIOLOGY THERAPEUTIC	93,365.00	1,280.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,496.00	672.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,849.00	3,037.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,474.00	14,068.00	TRAUMA RESPONSE	0.00	1,288.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,904.93	80,842.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,994.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,949.00	9,636.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,361.00	0.00			
AUDIOLOGY	4,220.00	2,486.50			
CARDIOLOGY	2,602.00	1,691.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	86,704.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,710.00	0.00			

TOTAL ANCILLARY	1,625,595.88	540,547.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,625,595.88	540,547.31

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,399,643.22	ADJUSTMENTS	21,459.22
COVERED CHARGES	1,272,060.17	CONTRACTUAL ALLOW	1,213,467.61
NON-COVERD CHARGES	127,583.05	TOTAL MEDICAID LIAB	58,592.56
		LESS: COB	19.19
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	58,570.37

TOTAL NUMBER OF CLAIMS 947

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,097.50	128.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,974.15	478.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,317.50	5,540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,377.50	41,158.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	281,026.87	59,764.50
EKG/ECG	2,453.50	0.00	MRI SERVICES	1,853.50	1,853.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,954.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	839.00	296.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	853.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	767,266.50	5,807.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,004.75	3,375.75
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	1,708.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	493.00	0.00	TRAUMA RESPONSE	0.00	1,288.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,058.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,566.00	2,774.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	600.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,123.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,547.50	3,410.00			

TOTAL ANCILLARY	1,272,060.17	127,583.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,272,060.17	127,583.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,974.66	ADJUSTMENTS	0.00
COVERED CHARGES	27,895.41	CONTRACTUAL ALLOW	13,770.38
NON-COVERD CHARGES	7,079.25	TOTAL MEDICAID LIAB	14,125.03
		LESS: COB	14,125.03
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	283.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,514.00	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	11,828.50	976.00
EKG/ECG	350.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	4,170.50
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	13,445.00	244.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285.75	70.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,617.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,895.41	7,079.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,895.41	7,079.25

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,859,635.39	ADJUSTMENTS	307,328.67
COVERED CHARGES	7,894,944.29	CONTRACTUAL ALLOW	6,419,453.88
NON-COVERD CHARGES	964,691.10	TOTAL MEDICAID LIAB	1,475,490.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,475,490.41

TOTAL NUMBER OF CLAIMS 178

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,280.00	0.00	OTHER LAB	0.00	7,834.00
MED/SURG SUPPLY	869,040.77	194.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,336.00	3,439.00	OTHER THERAPEUTIC SVC	0.00	184.00
CT SCAN	45,297.00	9,086.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,936.50	7,840.00	FEE SCHEDULE LAB	204,099.60	7,140.75
EKG/ECG	1,402.00	350.50	MRI SERVICES	62,463.50	10,158.00
IV THERAPY	58,591.50	1,526.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,404,565.50	547,740.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,420.18	10,865.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	953,791.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,231.50	3,740.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,936.50	1,107.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	124,127.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,056,203.50	78,269.25
RADIOLOGY THERAPEUTIC	39,760.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,179.00	2,808.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,705.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,837.50	7,179.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,469,175.24	161,684.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250.00	693.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,257.50	582.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	111.00	222.00			
CARDIOLOGY	2,779.00	9,812.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	198,464.50	3,350.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,703.00	88,883.00			

TOTAL ANCILLARY	7,894,944.29	964,691.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,894,944.29	964,691.10

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,230.29	ADJUSTMENTS	0.00
COVERED CHARGES	48,608.54	CONTRACTUAL ALLOW	10,202.02
NON-COVERD CHARGES	12,621.75	TOTAL MEDICAID LIAB	38,406.52
		LESS: COB	38,406.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	687.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,827.95	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	1,158.50	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	12,231.50	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	4,443.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,663.50	199.25
RADIOLOGY THERAPEUTIC	1,275.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	191.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,427.59	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,472.50	0.00			

TOTAL ANCILLARY	48,608.54	12,621.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,608.54	12,621.75

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,153.48	ADJUSTMENTS	0.00
COVERED CHARGES	49,588.48	CONTRACTUAL ALLOW	42,818.51
NON-COVERD CHARGES	565.00	TOTAL MEDICAID LIAB	6,769.97
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,769.97

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	8,428.00	565.00
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	8,428.00	565.00
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	8,428.00	565.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,378.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,961.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,628.67	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,783.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,065.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	921.50	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	8,519.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,902.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	41,160.48	0.00
TOTAL ACCOMODATIONS	8,428.00	565.00
TOTAL CHARGES	49,588.48	565.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,312,078.00	ADJUSTMENTS	39,036.38
COVERED CHARGES	2,201,056.74	CONTRACTUAL ALLOW	1,936,359.34
NON-COVERD CHARGES	111,021.26	TOTAL MEDICAID LIAB	264,697.40
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	264,514.40
		ALL OTHER	246,804.27
		FEE SCHEDULE-LAB	15,903.25
		INJECTABLE DRUGS	1,806.88

TOTAL NUMBER OF CLAIMS 916

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,813.61	87.50	OTHER LAB	3,968.80	0.00
MED/SURG SUPPLY	23,440.14	544.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,271.35	5,229.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	257,040.30	70,263.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,019.20	588.00	FEE SCHEDULE LAB	311,135.35	6,183.29
EKG/ECG	42,615.00	819.00	MRI SERVICES	0.00	0.00
IV THERAPY	133,137.50	4,878.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	435.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,981.50	7,779.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,055,133.05	2,786.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,672.04	8,893.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,426.00	2,352.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111.00	615.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,745.50	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	111.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,201,056.74	111,021.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,201,056.74	111,021.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338.00	ADJUSTMENTS	0.00
COVERED CHARGES	338.00	CONTRACTUAL ALLOW	86.02
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	251.98
		LESS: COB	251.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	338.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	338.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	295,926.50	ADJUSTMENTS	0.00
COVERED CHARGES	286,036.30	CONTRACTUAL ALLOW	277,636.30
NON-COVERD CHARGES	9,890.20	TOTAL MEDICAID LIAB	8,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	8,064.00
		TOTAL NUMBER OF CLAIMS	168

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,910.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,563.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,423.09	1,154.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,484.50	7,143.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,043.88	1,063.25
EKG/ECG	2,150.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,651.50	143.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	281.10	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	181,966.00	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	9,562.16	384.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	286,036.30	9,890.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	286,036.30	9,890.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	199,333.76	ADJUSTMENTS	0.00
COVERED CHARGES	182,356.76	CONTRACTUAL ALLOW	109,506.62
NON-COVERD CHARGES	16,977.00	TOTAL MEDICAID LIAB	72,850.14
		LESS: COB	555.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	72,294.67

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	102	0	76,500.00	15,550.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	102	0	76,500.00	15,550.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	102	0	76,500.00	15,550.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,120.00	234.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,300.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,696.00	477.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,755.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	805.00	285.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,140.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	325.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,955.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,391.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,147.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	506.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	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	2,126.02	0.00			

TOTAL ANCILLARY	105,856.76	1,427.00
TOTAL ACCOMODATIONS	76,500.00	15,550.00
TOTAL CHARGES	182,356.76	16,977.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	367,480.72	ADJUSTMENTS	6,536.39
COVERED CHARGES	314,394.50	CONTRACTUAL ALLOW	209,884.19
NON-COVERD CHARGES	53,086.22	TOTAL MEDICAID LIAB	104,510.31
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	104,195.31
		ALL OTHER	86,829.64
		FEE SCHEDULE-LAB	17,068.87
		INJECTABLE DRUGS	296.80

TOTAL NUMBER OF CLAIMS 357

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,275.00	4,704.00	OTHER LAB	11,105.00	0.00
MED/SURG SUPPLY	600.00	77.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,225.00	8,220.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,275.00	8,950.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,825.00	1,137.00	FEE SCHEDULE LAB	105,431.20	4,596.00
EKG/ECG	3,393.00	990.00	MRI SERVICES	13,475.00	1,500.00
IV THERAPY	4,020.00	1,410.00	PROFESSIONAL FEES	0.00	360.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,557.00	1,432.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,600.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,502.26	1,784.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,248.00	2,083.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	188.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	508.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,910.00	1,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,217.00	6,234.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,648.00	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	4,688.04	563.22			

TOTAL ANCILLARY	314,394.50	53,086.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	314,394.50	53,086.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,883.14	ADJUSTMENTS	0.00
COVERED CHARGES	13,995.14	CONTRACTUAL ALLOW	12,895.14
NON-COVERD CHARGES	888.00	TOTAL MEDICAID LIAB	1,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	1,070.00
		TOTAL NUMBER OF CLAIMS	22

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397.00	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	525.00	275.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,584.00	213.00
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	7,985.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	529.00	273.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	127.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,995.14	888.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,995.14	888.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,635,916.69	ADJUSTMENTS	111,631.22
COVERED CHARGES	2,623,845.69	CONTRACTUAL ALLOW	2,286,475.99
NON-COVERD CHARGES	12,071.00	TOTAL MEDICAID LIAB	337,369.70
		LESS: COB	4,702.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	332,667.07

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	95	0	122,740.00	8,930.00
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	95	0	122,740.00	8,930.00
SPECIAL CARE SERVICES				
CCU	262	0	658,668.00	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	262	0	658,668.00	0.00
TOTAL ACCOMODATIONS	357	0	781,408.00	8,930.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	372,173.50	0.00	OTHER LAB	19,119.00	0.00
MED/SURG SUPPLY	78,263.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	203,915.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,164.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,141.00
CT SCAN	30,769.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	59,287.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,632.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,633.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	841,170.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,262.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	466.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	557.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,347.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	38,285.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	222.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,841.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,242.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,002.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,884.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,699.00	0.00			

TOTAL ANCILLARY	1,842,437.69	3,141.00
TOTAL ACCOMODATIONS	781,408.00	8,930.00
TOTAL CHARGES	2,623,845.69	12,071.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,992,097.58	ADJUSTMENTS	89,939.31
COVERED CHARGES	2,775,022.58	CONTRACTUAL ALLOW	2,185,609.47
NON-COVERD CHARGES	217,075.00	TOTAL MEDICAID LIAB	589,413.11
		LESS: COB	4,160.81
		LESS: COPAYMENT	2,871.00
		REIMBURSEMENT	582,381.30
		ALL OTHER	519,240.37
		FEE SCHEDULE-LAB	827.46
		INJECTABLE DRUGS	62,313.47

TOTAL NUMBER OF CLAIMS 605

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,889.75	60.00	OTHER LAB	13,579.00	0.00
MED/SURG SUPPLY	61,394.90	530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,405.00	2,396.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	204,843.00	13,039.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	573,730.00	67,374.00	FEE SCHEDULE LAB	14,991.00	1,598.00
EKG/ECG	1,108.00	0.00	MRI SERVICES	154,898.00	8,487.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	468,261.00	107,819.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	228,260.00	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	115,129.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,730.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,042.00	374.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	30,979.68	3,318.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	60,114.00	988.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,726.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,821.00	4,516.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	429,737.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,775,022.58	217,075.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,775,022.58	217,075.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,972.54	ADJUSTMENTS	0.00
COVERED CHARGES	116,832.88	CONTRACTUAL ALLOW	48,107.21
NON-COVERD CHARGES	54,139.66	TOTAL MEDICAID LIAB	68,725.67
		LESS: COB	68,713.67
		LESS: COPAYMENT	12.00
		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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,779.00	60.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,989.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,211.00	476.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.00	FEE SCHEDULE LAB	253.00	0.00
EKG/ECG	92.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,349.00	47,434.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,414.00	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	9,952.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,002.00	265.50
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	10,008.52	5,228.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,425.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	870.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	116,832.88	54,139.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	116,832.88	54,139.66

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL
2540 WINDY HILL RD SE
MARIETTA,GA 30067-8605

PROVIDER NUMBER
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	586,835.34	ADJUSTMENTS	47,694.84
COVERED CHARGES	560,558.24	CONTRACTUAL ALLOW	494,957.21
NON-COVERD CHARGES	26,277.10	TOTAL MEDICAID LIAB	65,601.03
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	65,580.03
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,094.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,515.30	5,674.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,396.00	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	338.00	FEE SCHEDULE LAB	796.00	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	110,940.00	6,826.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,131.00	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	15,993.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,659.75	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	219,683.94	13,437.90
LITHOTRIPSY	77,349.00	1.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	560,558.24	26,277.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	560,558.24	26,277.10

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,564,829.16	ADJUSTMENTS	516,097.65
COVERED CHARGES	18,957,185.86	CONTRACTUAL ALLOW	13,643,387.64
NON-COVERD CHARGES	607,643.30	TOTAL MEDICAID LIAB	5,313,798.22
		LESS: COB	84,674.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,229,123.58

TOTAL NUMBER OF ADMISSIONS 598

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	897	0	864,830.00	171,219.00
ROUTINE NURSERY	203	0	207,353.00	20,827.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,100	0	1,072,183.00	192,046.00
SPECIAL CARE SERVICES				
CCU	1,082	0	2,062,656.00	0.00
ICU	445	0	1,207,036.00	44,889.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,527	0	3,269,692.00	44,889.00
TOTAL ACCOMODATIONS	2,627	0	4,341,875.00	236,935.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,770,873.21	78,321.25	OTHER LAB	107,717.30	0.00
MED/SURG SUPPLY	617,367.56	5,227.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,717,195.13	42,897.00	EDUCATION & TRAINING	1,494.60	0.00
RADIOLOGY-DIAGNOSTIC	311,502.50	6,774.00	OTHER THERAPEUTIC SVC	0.00	1,053.80
CT SCAN	1,209,386.60	40,649.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	113,665.35	523.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	263,016.75	1,536.00	MRI SERVICES	181,487.00	0.00
IV THERAPY	176,698.40	1,199.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,332,551.90	20,465.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	253,893.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,130,392.70	1,963.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343,843.43	2,579.00	AMBULANCE	0.00	0.00
GI SERVICES	77,702.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,198,345.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	147,299.00	72.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	123,792.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	105,283.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,290.82	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,877.20	0.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	166,229.60	78,473.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,006.90	762.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	432,746.39	861.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	129,460.40	8,375.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	207,338.80	64,099.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	171,079.40	14,878.20			
AUDIOLOGY	7,729.80	0.00			
CARDIOLOGY	1,194,845.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94,064.17	0.00			

TOTAL ANCILLARY	14,615,310.86	370,708.30
TOTAL ACCOMODATIONS	4,341,875.00	236,935.00
TOTAL CHARGES	18,957,185.86	607,643.30

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,273.74	ADJUSTMENTS	0.00
COVERED CHARGES	85,299.74	CONTRACTUAL ALLOW	60,544.88
NON-COVERD CHARGES	2,974.00	TOTAL MEDICAID LIAB	24,754.86
		LESS: COB	24,754.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10	0	9,850.00	2,974.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	9,850.00	2,974.00
SPECIAL CARE SERVICES				
CCU	1	0	2,514.00	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	2,514.00	0.00
TOTAL ACCOMODATIONS	11	0	12,364.00	2,974.00

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
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,297.15	0.00	OTHER LAB	12,317.00	0.00
MED/SURG SUPPLY	2,076.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,857.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,364.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,667.20	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	1,649.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,798.00	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	6,715.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	668.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,334.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,191.50	0.00			

TOTAL ANCILLARY	72,935.74	0.00
TOTAL ACCOMODATIONS	12,364.00	2,974.00
TOTAL CHARGES	85,299.74	2,974.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,976,796.34	ADJUSTMENTS	496,830.13
COVERED CHARGES	16,194,154.90	CONTRACTUAL ALLOW	13,549,410.43
NON-COVERD CHARGES	1,782,641.44	TOTAL MEDICAID LIAB	2,644,744.47
		LESS: COB	7,435.30
		LESS: COPAYMENT	4,800.00
		REIMBURSEMENT	2,632,509.17
		ALL OTHER	2,312,688.83
		FEE SCHEDULE-LAB	220,389.11
		INJECTABLE DRUGS	99,431.23

TOTAL NUMBER OF CLAIMS 5,783

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,002.77	0.00	OTHER LAB	240,883.20	1,556.00
MED/SURG SUPPLY	356,112.16	88,018.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	179.20
RADIOLOGY-DIAGNOSTIC	605,369.00	48,277.40	OTHER THERAPEUTIC SVC	0.00	961.60
CT SCAN	1,690,751.20	271,965.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,526.30	4,175.70	FEE SCHEDULE LAB	2,986,119.62	139,134.60
EKG/ECG	301,626.65	25,086.50	MRI SERVICES	152,500.00	27,070.00
IV THERAPY	577,099.80	42,483.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,257,100.71	190,030.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,088.30	0.00	REHAB THERAPY	0.00	6,836.20
RESPIRATORY SERVICES	177,362.30	15,212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	513,561.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	127,455.50	22,626.20	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,818,458.07	92,194.93	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	248,447.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	342,608.82	282,662.69
RADIOLOGY THERAPEUTIC	329,030.90	201,317.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,393.00	496.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	847.00	0.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,685.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,721.80	2,775.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,602.20	420.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	398,356.30	46,238.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,837.70	3,789.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	269,138.40	71,554.10			
AUDIOLOGY	572.20	204.40			
CARDIOLOGY	717,657.30	174,368.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	142,131.00	1,027.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	417,793.90	19,293.90			

TOTAL ANCILLARY	16,194,154.90	1,782,641.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,194,154.90	1,782,641.44

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	279,118.76	ADJUSTMENTS	0.00
COVERED CHARGES	229,505.21	CONTRACTUAL ALLOW	89,947.95
NON-COVERD CHARGES	49,613.55	TOTAL MEDICAID LIAB	139,557.26
		LESS: COB	139,536.26
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,410.01	0.00	OTHER LAB	6,859.20	0.00
MED/SURG SUPPLY	8,408.35	1,991.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,399.70	5,468.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,544.00	16,038.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	47,977.40	1,028.20
EKG/ECG	3,437.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,696.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,709.75	13,907.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	864.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,205.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,031.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,501.50	1,009.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,173.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	889.60	267.75
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	111.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,397.00	9,792.20			
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			

TOTAL ANCILLARY	229,505.21	49,613.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,505.21	49,613.55

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,313,275.45	ADJUSTMENTS	539.54
COVERED CHARGES	1,251,990.70	CONTRACTUAL ALLOW	1,207,686.22
NON-COVERD CHARGES	61,284.75	TOTAL MEDICAID LIAB	44,304.48
		LESS: COB	1.86
		LESS: COPAYMENT	1,461.00
		REIMBURSEMENT	42,841.62
		TOTAL NUMBER OF CLAIMS	792

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,895.90	0.00	OTHER LAB	4,906.00	0.00
MED/SURG SUPPLY	4,264.30	59.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,955.40	12,307.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	120,531.40	21,008.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	201,336.40	7,906.00
EKG/ECG	22,673.00	687.50	MRI SERVICES	0.00	0.00
IV THERAPY	11,806.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,723.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,991.60	1,733.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	763,212.70	11,370.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,329.80	1,051.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,962.70	4,938.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,401.90	0.00			

TOTAL ANCILLARY	1,251,990.70	61,284.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,251,990.70	61,284.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,649.55	ADJUSTMENTS	0.00
COVERED CHARGES	19,426.95	CONTRACTUAL ALLOW	9,080.75
NON-COVERD CHARGES	1,222.60	TOTAL MEDICAID LIAB	10,346.20
		LESS: COB	10,334.20
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	381.50	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	545.00	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	5,562.50	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	12,875.70	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	62.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,222.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,426.95	1,222.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,426.95	1,222.60

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,442,781.28	ADJUSTMENTS	193,160.28
COVERED CHARGES	2,271,041.76	CONTRACTUAL ALLOW	1,899,511.35
NON-COVERD CHARGES	171,739.52	TOTAL MEDICAID LIAB	371,530.41
		LESS: COB	592.77
		LESS: COPAYMENT	717.00
		REIMBURSEMENT	370,220.64

TOTAL NUMBER OF CLAIMS 67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,713.74	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	253,970.94	686.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,899.00	709.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,189.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	989.42	FEE SCHEDULE LAB	44,389.70	1,369.40
EKG/ECG	2,223.50	2,406.25	MRI SERVICES	0.00	0.00
IV THERAPY	96,972.30	2,611.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	311,818.80	25,728.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	964.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,146.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,033.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	615,410.26	36,526.35
RADIOLOGY THERAPEUTIC	658,977.00	61,038.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,518.80	111.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,364.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,199.90	3,066.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,723.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,880.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	113,748.60	35,103.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,897.62	1,393.00			

TOTAL ANCILLARY	2,271,041.76	171,739.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,271,041.76	171,739.52

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	665,304.07	ADJUSTMENTS	20,327.00
COVERED CHARGES	634,736.07	CONTRACTUAL ALLOW	429,207.26
NON-COVERD CHARGES	30,568.00	TOTAL MEDICAID LIAB	205,528.81
		LESS: COB	1,880.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	203,648.23

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	164	0	82,000.00	25,710.00
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	164	0	82,000.00	25,710.00
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	164	0	82,000.00	25,710.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,358.07	0.00	OTHER LAB	474.00	0.00
MED/SURG SUPPLY	52,959.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,258.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,626.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,933.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,713.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,546.00	246.00	MRI SERVICES	1,503.00	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	218,447.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,147.00	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	1,608.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	404.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,114.00	4,612.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,976.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,670.00	0.00			

TOTAL ANCILLARY	552,736.07	4,858.00
TOTAL ACCOMODATIONS	82,000.00	25,710.00
TOTAL CHARGES	634,736.07	30,568.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	789,275.75	ADJUSTMENTS	49,603.43
COVERED CHARGES	700,124.75	CONTRACTUAL ALLOW	395,553.63
NON-COVERD CHARGES	89,151.00	TOTAL MEDICAID LIAB	304,571.12
		LESS: COB	400.00
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	303,565.12
		ALL OTHER	275,398.59
		FEE SCHEDULE-LAB	26,810.82
		INJECTABLE DRUGS	1,355.71

TOTAL NUMBER OF CLAIMS 756

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,915.75	4,881.00	OTHER LAB	7,070.00	0.00
MED/SURG SUPPLY	45,970.00	660.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,268.00	8,317.00	OTHER THERAPEUTIC SVC	0.00	162.00
CT SCAN	84,694.00	6,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,968.00	100.00	FEE SCHEDULE LAB	127,507.00	10,667.00
EKG/ECG	10,256.00	582.00	MRI SERVICES	5,520.00	0.00
IV THERAPY	0.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,774.00	3,543.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,246.00	18,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	242,032.00	18,210.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,864.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,608.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	250.00	560.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,315.00	1,601.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,552.00	412.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,568.00	1,153.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,902.00	7,814.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,640.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,205.00	5,668.00			

TOTAL ANCILLARY	700,124.75	89,151.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	700,124.75	89,151.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,140.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,383.00	CONTRACTUAL ALLOW	1,294.83
NON-COVERD CHARGES	6,757.00	TOTAL MEDICAID LIAB	11,088.17
		LESS: COB	11,085.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	941.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,092.00	8.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	273.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,029.00	4,530.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,279.00	134.00
EKG/ECG	291.00	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	2,778.00	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	5.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,744.00			
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	792.00	68.00			

TOTAL ANCILLARY	12,383.00	6,757.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,383.00	6,757.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,552.50	ADJUSTMENTS	50.00
COVERED CHARGES	55,573.50	CONTRACTUAL ALLOW	51,073.50
NON-COVERD CHARGES	979.00	TOTAL MEDICAID LIAB	4,500.00
		LESS: COB	18.56
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	4,265.44
		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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,305.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,735.00	8.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,050.00	176.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,879.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,944.00	795.00
EKG/ECG	287.00	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	485.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	446.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	90.00	0.00			

TOTAL ANCILLARY	55,573.50	979.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,573.50	979.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,175.00	ADJUSTMENTS	4,862.89
COVERED CHARGES	34,573.00	CONTRACTUAL ALLOW	19,984.33
NON-COVERD CHARGES	602.00	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	14,585.67

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,035.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,273.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	519.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,095.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,034.00	83.00
EKG/ECG	97.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,297.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,760.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	262.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	544.00	0.00			

TOTAL ANCILLARY	34,573.00	602.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,573.00	602.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,740,210.13	ADJUSTMENTS	0.00
COVERED CHARGES	4,555,571.13	CONTRACTUAL ALLOW	3,474,000.34
NON-COVERD CHARGES	184,639.00	TOTAL MEDICAID LIAB	1,081,570.79
		LESS: COB	10,256.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,071,314.70

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	346	0	266,874.00	157,742.00
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	346	0	266,874.00	157,742.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	77	0	195,255.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	77	0	195,255.00	0.00
TOTAL ACCOMODATIONS	423	0	462,129.00	157,742.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	717,735.00	0.00	OTHER LAB	15,525.00	0.00
MED/SURG SUPPLY	253,171.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	682,282.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	520,277.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,583.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	55,080.00	0.00	MRI SERVICES	44,061.00	0.00
IV THERAPY	219,334.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,401.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	440,367.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,622.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	245,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,735.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	33,527.00	0.00	INJECTABLE DRUGS	15,325.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,166.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,578.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	452.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	196,461.77	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,683.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,882.00	12,887.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,305.00	8,694.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	126,757.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,967.00	5,316.00			

TOTAL ANCILLARY	4,093,442.13	26,897.00
TOTAL ACCOMODATIONS	462,129.00	157,742.00
TOTAL CHARGES	4,555,571.13	184,639.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,848.00	ADJUSTMENTS	0.00
COVERED CHARGES	74,890.00	CONTRACTUAL ALLOW	53,989.30
NON-COVERD CHARGES	958.00	TOTAL MEDICAID LIAB	20,900.70
		LESS: COB	20,900.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,496.00	958.00
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	1,496.00	958.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	10,260.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	10,260.00	0.00
TOTAL ACCOMODATIONS	6	0	11,756.00	958.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,490.00	0.00	OTHER LAB	1,366.00	0.00
MED/SURG SUPPLY	4,195.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,314.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,153.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,772.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	13,419.00	0.00
IV THERAPY	2,119.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,407.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,668.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,619.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	63,134.00	0.00
TOTAL ACCOMODATIONS	11,756.00	958.00
TOTAL CHARGES	74,890.00	958.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,302,597.59	ADJUSTMENTS	179,571.55
COVERED CHARGES	7,314,387.43	CONTRACTUAL ALLOW	5,949,399.73
NON-COVERD CHARGES	988,210.16	TOTAL MEDICAID LIAB	1,364,987.70
		LESS: COB	831.34
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	1,362,476.36
		ALL OTHER	1,272,209.90
		FEE SCHEDULE-LAB	80,398.88
		INJECTABLE DRUGS	9,867.58

TOTAL NUMBER OF CLAIMS 2,076

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,618.00	95,884.00	OTHER LAB	44,595.00	0.00
MED/SURG SUPPLY	121,642.64	5,415.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	337,980.00	62,128.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,767,772.00	190,874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,492.00	FEE SCHEDULE LAB	994,279.79	125,427.40
EKG/ECG	115,387.00	2,142.00	MRI SERVICES	218,363.00	15,406.00
IV THERAPY	569,077.00	57,927.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205,605.84	172,410.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,629.00	9,307.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	150,825.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,751,893.00	1,622.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	275,251.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227,983.00	91,955.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,070.00	7,198.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	197.16	61,136.15
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	119,444.00	10,710.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,034.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,303.00	27,408.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,153.00	26,195.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	181,285.00	23,573.00			

TOTAL ANCILLARY	7,314,387.43	988,210.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,314,387.43	988,210.16

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 BARROW, LLC
316 N BROAD ST
WINDER,GA 30680-2150

PROVIDER NUMBER
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,050.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,828.00	CONTRACTUAL ALLOW	17,227.20
NON-COVERD CHARGES	6,222.00	TOTAL MEDICAID LIAB	19,600.80
		LESS: COB	19,600.80
		LESS: COPAYMENT	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	442.00	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	3,566.00	1,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,550.00	4,510.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,475.00	72.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,116.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,692.00	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	89.00	126.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,828.00	6,222.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,828.00	6,222.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	281,070.00	ADJUSTMENTS	1,895.77
COVERED CHARGES	265,721.00	CONTRACTUAL ALLOW	255,819.55
NON-COVERD CHARGES	15,349.00	TOTAL MEDICAID LIAB	9,901.45
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	9,637.45
		TOTAL NUMBER OF CLAIMS	170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	766.00	816.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	191.00	370.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,246.00	4,647.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,274.00	2,255.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,601.00	2,210.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,265.00	1,216.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,567.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,909.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,104.00	1,977.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	761.00	1,858.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,425.00	0.00			

TOTAL ANCILLARY	265,721.00	15,349.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	265,721.00	15,349.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,470.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,046.00	CONTRACTUAL ALLOW	7,670.57
NON-COVERD CHARGES	2,424.00	TOTAL MEDICAID LIAB	4,375.43
		LESS: COB	4,372.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,059.00	2,255.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,284.00	72.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,208.00	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	2,872.00	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	473.00	97.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,046.00	2,424.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,046.00	2,424.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	950,145.39	ADJUSTMENTS	43,503.80
COVERED CHARGES	725,397.75	CONTRACTUAL ALLOW	600,263.95
NON-COVERD CHARGES	224,747.64	TOTAL MEDICAID LIAB	125,133.80
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	125,082.80
		TOTAL NUMBER OF CLAIMS	23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,017.00	3,134.00	OTHER LAB	2,564.00	0.00
MED/SURG SUPPLY	92,525.37	4,315.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,091.00	862.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,772.00	7,307.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,486.00	6,121.00
EKG/ECG	5,202.00	0.00	MRI SERVICES	7,997.00	0.00
IV THERAPY	41,861.00	11,782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,674.67	71,863.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,327.00	2,217.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,747.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,620.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	99,636.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,381.00	10,385.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,519.71	70,485.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,640.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,288.00	10,527.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,974.00	6,859.00			
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	15,075.00	18,777.00			

TOTAL ANCILLARY	725,397.75	224,747.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	725,397.75	224,747.64

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA,GA 30303-3032

PROVIDER NUMBER
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,652,897.54	ADJUSTMENTS	9,006.13
COVERED CHARGES	9,617,196.30	CONTRACTUAL ALLOW	7,472,658.06
NON-COVERD CHARGES	35,701.24	TOTAL MEDICAID LIAB	2,144,538.24
		LESS: COB	1,967.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,142,570.74

TOTAL NUMBER OF ADMISSIONS 299

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	881	0	1,122,394.00	2,205.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	881	0	1,122,394.00	2,205.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	881	0	1,122,394.00	2,205.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	763,043.00	0.00	OTHER LAB	3,753.00	0.00
MED/SURG SUPPLY	124,398.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	862,088.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,688.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,856.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,282.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,860.00	0.00	MRI SERVICES	10,717.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,696.24
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,292,368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,091,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,245.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	324.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	17,481.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,022.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,337.00	4,192.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,220.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,960.80	10,127.00			

TOTAL ANCILLARY	8,494,802.30	33,496.24
TOTAL ACCOMODATIONS	1,122,394.00	2,205.00
TOTAL CHARGES	9,617,196.30	35,701.24

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,688.50	ADJUSTMENTS	0.00
COVERED CHARGES	27,688.50	CONTRACTUAL ALLOW	17,433.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,254.55
		LESS: COB	10,254.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	6,370.00	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	6,370.00	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	0	6,370.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,930.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	200.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,808.00	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	11,677.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,703.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,318.50	0.00
TOTAL ACCOMODATIONS	6,370.00	0.00
TOTAL CHARGES	27,688.50	0.00

HUGHES SPALDING CHILDRENS HOSP
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ATLANTA,GA 30303-3032

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,126,369.72	ADJUSTMENTS	334,827.17
COVERED CHARGES	21,490,564.15	CONTRACTUAL ALLOW	17,187,012.81
NON-COVERD CHARGES	1,635,805.57	TOTAL MEDICAID LIAB	4,303,551.34
		LESS: COB	14,915.60
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	4,288,614.74
		ALL OTHER	3,724,439.68
		FEE SCHEDULE-LAB	155,928.30
		INJECTABLE DRUGS	408,246.76

TOTAL NUMBER OF CLAIMS 10,846

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,174.50	0.00	OTHER LAB	240,671.00	23,862.00
MED/SURG SUPPLY	407,255.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	772,742.00	9,481.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	131,002.00	7,428.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,050,739.50	288,929.00
EKG/ECG	42,687.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,484.00	0.00	PROFESSIONAL FEES	0.00	1,815.91
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,090,195.02	605,268.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,307,272.64	104,430.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,467,137.39	177,160.98
RADIOLOGY THERAPEUTIC	19,764.00	648.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.23
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,845,870.50	387,769.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,400.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,903.50
OTHER IMAGING SERVICE	126,396.00	9,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	314,674.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	720.00	30.00			
CARDIOLOGY	43,963.00	13,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	239,416.60	3,890.90			

TOTAL ANCILLARY	21,490,564.15	1,635,805.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,490,564.15	1,635,805.57

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 01/01/18 THROUGH 12/31/18
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	2018195010171	02/21/18 - 02/21/18	07/23/18	0.00	951.75	0.00	0.00	0.00
970	2019008072378	10/08/18 - 10/08/18	01/14/19	0.00	951.75	0.00	0.00	0.00
TOTAL				0.00	1,903.50	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	132,134.76	ADJUSTMENTS	0.00
COVERED CHARGES	118,143.26	CONTRACTUAL ALLOW	63,319.99
NON-COVERD CHARGES	13,991.50	TOTAL MEDICAID LIAB	54,823.27
		LESS: COB	54,823.27
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,027.75	0.00	OTHER LAB	2,466.00	0.00
MED/SURG SUPPLY	7,392.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,510.00	1,407.00	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	17,290.00	1,102.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	692.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,258.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,897.00	1,924.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223.50	153.50
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	22,341.00	3,719.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,898.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,738.00	2,096.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	118,143.26	13,991.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	118,143.26	13,991.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,885,138.90	ADJUSTMENTS	25,945.74
COVERED CHARGES	1,858,760.75	CONTRACTUAL ALLOW	1,790,688.35
NON-COVERD CHARGES	26,378.15	TOTAL MEDICAID LIAB	68,072.40
		LESS: COB	36.99
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	68,032.41
		TOTAL NUMBER OF CLAIMS	1,098

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,963.25	1,661.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,805.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,785.00	5,542.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	181,011.00	12,704.00
EKG/ECG	3,430.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	260.40
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,563.00	3,426.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,558,441.00	695.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,415.50	677.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	492.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,442.00	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	1,652.30	0.00			

TOTAL ANCILLARY	1,858,760.75	26,378.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,858,760.75	26,378.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,729.25	ADJUSTMENTS	0.00
COVERED CHARGES	21,490.50	CONTRACTUAL ALLOW	12,976.53
NON-COVERD CHARGES	238.75	TOTAL MEDICAID LIAB	8,513.97
		LESS: COB	8,513.97
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	526.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,962.00	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	562.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	198.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	576.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,854.00	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	10.50	40.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,490.50	238.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,490.50	238.75

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,112.83	ADJUSTMENTS	0.00
COVERED CHARGES	7,112.83	CONTRACTUAL ALLOW	4,693.65
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,419.18
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,419.18

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	1,038.00	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	1,038.00	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	1,038.00	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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	342.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	903.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	297.00	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	2,987.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,074.83	0.00
TOTAL ACCOMODATIONS	1,038.00	0.00
TOTAL CHARGES	7,112.83	0.00

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,727,631.30	ADJUSTMENTS	219.58
COVERED CHARGES	1,370,177.10	CONTRACTUAL ALLOW	1,077,008.85
NON-COVERD CHARGES	357,454.20	TOTAL MEDICAID LIAB	293,168.25
		LESS: COB	1,707.71
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	291,409.54
		ALL OTHER	254,748.69
		FEE SCHEDULE-LAB	32,096.37
		INJECTABLE DRUGS	4,564.48

TOTAL NUMBER OF CLAIMS 625

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,305.04	5,503.22	OTHER LAB	4,566.00	1,225.00
MED/SURG SUPPLY	1,939.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,299.00	38,129.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,574.00	190,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,943.00	FEE SCHEDULE LAB	356,048.00	30,601.00
EKG/ECG	32,305.00	3,550.00	MRI SERVICES	0.00	0.00
IV THERAPY	100,605.00	9,512.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,394.00	15,988.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	687,857.00	4,798.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,022.06	25,813.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	702.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,530.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,610.00	3,460.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	722.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	17,804.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,760.00	3,906.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,171.00	817.00			

TOTAL ANCILLARY	1,370,177.10	357,454.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,370,177.10	357,454.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,156.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,661.35	CONTRACTUAL ALLOW	-1,273.64
NON-COVERD CHARGES	4,494.65	TOTAL MEDICAID LIAB	9,934.99
		LESS: COB	9,934.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186.25	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	3,842.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,997.00	305.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	719.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,663.00	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	96.10	347.65
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,661.35	4,494.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,661.35	4,494.65

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	161,126.80	ADJUSTMENTS	0.00
COVERED CHARGES	140,474.55	CONTRACTUAL ALLOW	135,719.65
NON-COVERD CHARGES	20,652.25	TOTAL MEDICAID LIAB	4,754.90
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	4,562.90
		TOTAL NUMBER OF CLAIMS	85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,230.30	0.00	OTHER LAB	761.00	0.00
MED/SURG SUPPLY	49.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,659.00	1,347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,515.00	15,495.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,010.00	1,906.00
EKG/ECG	1,420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,035.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	197.00	816.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,500.00	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	4,098.25	1,088.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	140,474.55	20,652.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	140,474.55	20,652.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 12/29/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,954,568.61	ADJUSTMENTS	69,658.82
COVERED CHARGES	7,932,412.61	CONTRACTUAL ALLOW	5,435,081.45
NON-COVERD CHARGES	22,156.00	TOTAL MEDICAID LIAB	2,497,331.16
		LESS: COB	36,483.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,460,847.56

TOTAL NUMBER OF ADMISSIONS 299

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	988	0	592,930.00	8,709.00
ROUTINE NURSERY	75	0	40,350.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,063	0	633,280.00	8,709.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	108	0	151,416.00	0.00
NICU	19	0	22,078.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	127	0	173,494.00	0.00
TOTAL ACCOMODATIONS	1,190	0	806,774.00	8,709.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697,025.36	0.00	OTHER LAB	26,990.00	0.00
MED/SURG SUPPLY	710,864.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	784,213.26	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150,795.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	402,551.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	141,120.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,626.00	0.00	MRI SERVICES	74,388.00	0.00
IV THERAPY	38,447.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	764,165.00	5,041.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,036.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	216,308.37	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	229,006.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	397,780.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	215,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	28,798.00	0.00	INJECTABLE DRUGS	1,068,486.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,232.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,413.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	229.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	652,553.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,242.00
OTHER IMAGING SERVICE	50,576.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	86,159.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,070.00	0.00			
AUDIOLOGY	20,384.00	0.00			
CARDIOLOGY	90,602.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,052.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,908.00	1,935.00			

TOTAL ANCILLARY	7,125,638.61	13,447.00
TOTAL ACCOMODATIONS	806,774.00	8,709.00
TOTAL CHARGES	7,932,412.61	22,156.00

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 08/01/17 THROUGH 07/31/18
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	2117353000037	10/16/17 - 10/18/17	01/01/18	0.00	3,121.00	0.00	1,522.17	0.00
615	2018198088637	10/11/17 - 10/14/17	07/23/18	0.00	3,121.00	0.00	0.00	0.00
TOTAL				0.00	6,242.00	0.00	1,522.17	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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE SUMTER MEDICAL CENTER
126 US HWY 280 W
AMERICUS,GA 31719-8645

PROVIDER NUMBER
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,226,339.96	ADJUSTMENTS	491,436.94
COVERED CHARGES	8,608,089.75	CONTRACTUAL ALLOW	6,725,313.38
NON-COVERD CHARGES	618,250.21	TOTAL MEDICAID LIAB	1,882,776.37
		LESS: COB	742.68
		LESS: COPAYMENT	4,574.05
		REIMBURSEMENT	1,877,459.64
		ALL OTHER	1,496,031.61
		FEE SCHEDULE-LAB	126,122.95
		INJECTABLE DRUGS	255,305.08

TOTAL NUMBER OF CLAIMS 3,795

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397,135.15	263.46	OTHER LAB	47,765.96	0.00
MED/SURG SUPPLY	384,439.16	36.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	88.00
RADIOLOGY-DIAGNOSTIC	395,722.00	21,786.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,066,474.00	52,857.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,089.00	8,331.00	FEE SCHEDULE LAB	688,869.08	53,632.57
EKG/ECG	78,208.00	5,500.00	MRI SERVICES	216,789.00	18,482.00
IV THERAPY	207,958.00	50,029.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	846,105.57	60,212.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,050.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,088.31	21,659.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,550.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,582,863.75	66,694.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	462,992.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,650.21	224,676.57
RADIOLOGY THERAPEUTIC	57,629.49	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,795.00	807.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,765.00	1,097.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,896.00	1,303.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,248.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	177,702.39	3,101.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,104.00	1,116.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,029.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	69,438.00	11,712.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,040.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	130,693.59	14,867.00			

TOTAL ANCILLARY	8,608,089.75	618,250.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,608,089.75	618,250.21

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,117.95	ADJUSTMENTS	0.00
COVERED CHARGES	79,050.37	CONTRACTUAL ALLOW	22,946.77
NON-COVERD CHARGES	31,067.58	TOTAL MEDICAID LIAB	56,103.60
		LESS: COB	56,083.14
		LESS: COPAYMENT	20.46
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,399.36	737.40	OTHER LAB	850.00	0.00
MED/SURG SUPPLY	2,129.23	3,824.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	962.00	1,280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,005.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,172.51	610.00
EKG/ECG	660.00	220.00	MRI SERVICES	2,533.00	0.00
IV THERAPY	6,513.00	1,012.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,323.50	7,988.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,251.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,430.75	1,480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,994.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,962.02	2,450.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	868.74
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,379.00	1,464.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,916.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	9,132.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,838.00	0.00			

TOTAL ANCILLARY	79,050.37	31,067.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,050.37	31,067.58

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,029.08	ADJUSTMENTS	692.06
COVERED CHARGES	159,834.93	CONTRACTUAL ALLOW	150,336.29
NON-COVERD CHARGES	5,194.15	TOTAL MEDICAID LIAB	9,498.64
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	9,183.64
		TOTAL NUMBER OF CLAIMS	167

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,275.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,825.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,591.00	666.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,378.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,161.00	898.00
EKG/ECG	880.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	420.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	282.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,462.50	740.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,308.68	2,713.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	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	0.00	177.00			

TOTAL ANCILLARY	159,834.93	5,194.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,834.93	5,194.15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,227.25	ADJUSTMENTS	0.00
COVERED CHARGES	3,238.25	CONTRACTUAL ALLOW	1,003.03
NON-COVERD CHARGES	3,989.00	TOTAL MEDICAID LIAB	2,235.22
		LESS: COB	2,235.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	483.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,962.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	125.00	27.00
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	1,461.00	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	705.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,238.25	3,989.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,238.25	3,989.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,672,602.62	ADJUSTMENTS	92,020.84
COVERED CHARGES	1,614,123.98	CONTRACTUAL ALLOW	1,256,870.64
NON-COVERD CHARGES	58,478.64	TOTAL MEDICAID LIAB	357,253.34
		LESS: COB	2,845.61
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	354,191.73

TOTAL NUMBER OF CLAIMS 62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,289.70	373.15	OTHER LAB	1,280.00	0.00
MED/SURG SUPPLY	57,892.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,890.00	2,657.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	502.00	FEE SCHEDULE LAB	13,401.00	552.00
EKG/ECG	220.00	440.00	MRI SERVICES	0.00	4,007.00
IV THERAPY	35,900.00	4,538.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,241.00	3,358.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	480.00	292.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,134.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,246.00	2,011.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,981.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,243,188.66	37,798.01
RADIOLOGY THERAPEUTIC	64,032.89	495.54	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	276.00	76.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,656.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	387.00	558.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,628.00	820.00			

TOTAL ANCILLARY	1,614,123.98	58,478.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,614,123.98	58,478.64

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL
915 GORDON AVE
THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,550,910.53	ADJUSTMENTS	469,014.83
COVERED CHARGES	29,976,786.53	CONTRACTUAL ALLOW	19,578,289.99
NON-COVERD CHARGES	2,574,124.00	TOTAL MEDICAID LIAB	10,398,496.54
		LESS: COB	93,842.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,304,653.88

TOTAL NUMBER OF ADMISSIONS 1,137

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,237	0	4,094,016.00	2,308,103.00
ROUTINE NURSERY	65	0	42,493.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,302	0	4,136,509.00	2,308,103.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	981	0	1,680,704.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	981	0	1,680,704.00	0.00
TOTAL ACCOMODATIONS	7,283	0	5,817,213.00	2,308,103.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,489,872.76	8,168.00	OTHER LAB	52,113.00	0.00
MED/SURG SUPPLY	2,056,428.99	12,083.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,898,555.00	14,778.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	438,467.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361,478.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	255,893.82	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	81,068.00	0.00	MRI SERVICES	257,393.00	0.00
IV THERAPY	193,540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,210,553.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	86,360.00	97.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,106,466.00	9,278.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	148,288.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	128,288.00	1,399.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,164,033.00	3,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	184,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	95,612.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	363,200.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	160,065.99	132.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	70,217.97	115.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	220,330.00	5,562.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	10,991.00	TRAUMA RESPONSE	0.00	8,928.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,670,934.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,278.00	5,240.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	333,424.00	185,849.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	83,777.00	0.00			
AUDIOLOGY	12,750.00	0.00			
CARDIOLOGY	851,888.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,716.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,573.00	110.00			

TOTAL ANCILLARY	24,159,573.53	266,021.00
TOTAL ACCOMODATIONS	5,817,213.00	2,308,103.00
TOTAL CHARGES	29,976,786.53	2,574,124.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,686.03	ADJUSTMENTS	0.00
COVERED CHARGES	40,587.03	CONTRACTUAL ALLOW	24,273.67
NON-COVERD CHARGES	4,099.00	TOTAL MEDICAID LIAB	16,313.36
		LESS: COB	16,313.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	5,760.00	4,099.00
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	5,760.00	4,099.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,608.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	3,608.00	0.00
TOTAL ACCOMODATIONS	11	0	9,368.00	4,099.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,703.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,492.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,102.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	674.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,644.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	214.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,109.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,095.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,428.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	149.00	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	150.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	459.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,219.03	0.00
TOTAL ACCOMODATIONS	9,368.00	4,099.00
TOTAL CHARGES	40,587.03	4,099.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,184,398.51	ADJUSTMENTS	613,902.01
COVERED CHARGES	15,454,894.62	CONTRACTUAL ALLOW	12,184,996.01
NON-COVERD CHARGES	1,729,503.89	TOTAL MEDICAID LIAB	3,269,898.61
		LESS: COB	5,286.05
		LESS: COPAYMENT	14,244.98
		REIMBURSEMENT	3,250,367.58
		ALL OTHER	2,422,492.96
		FEE SCHEDULE-LAB	288,776.16
		INJECTABLE DRUGS	539,098.46

TOTAL NUMBER OF CLAIMS 8,565

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331,693.12	19,516.00	OTHER LAB	85,288.00	0.00
MED/SURG SUPPLY	805,408.00	3,149.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	531,781.00	30,443.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,463,646.00	169,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,281.00	21,582.36	FEE SCHEDULE LAB	2,077,713.90	158,538.20
EKG/ECG	83,857.00	235.00	MRI SERVICES	452,715.00	23,577.00
IV THERAPY	133,758.00	35,530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,191,139.36	253,604.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,490.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	110,713.00	37,888.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,919.00	260.00	AMBULANCE	0.00	0.00
GI SERVICES	312,077.45	58,026.55	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,626,763.21	34,126.59	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	224,464.00	4,216.00	DRUG-SPECIFIC/HOME IV	0.00	5,500.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,197,816.58	606,988.34
RADIOLOGY THERAPEUTIC	1,055,397.00	3,230.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,088.00	11,382.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,028.00	5,130.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	390,092.00	9,486.00	TRAUMA RESPONSE	0.00	12,078.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	261,748.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	362,018.00	29,309.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,075.00	43,272.00			
ONCOLOGY	25,160.00	0.00			
NUCLEAR MEDICINE	308,038.00	40,986.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	505,806.00	64,458.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	204,870.00	340.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	433,051.00	47,452.00			

TOTAL ANCILLARY	15,454,894.62	1,729,503.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,454,894.62	1,729,503.89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	98,431.00	ADJUSTMENTS	0.00
COVERED CHARGES	69,204.00	CONTRACTUAL ALLOW	13,391.79
NON-COVERD CHARGES	29,227.00	TOTAL MEDICAID LIAB	55,812.21
		LESS: COB	55,748.44
		LESS: COPAYMENT	63.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,214.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,418.00	455.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,802.00	1,222.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,983.00	140.00	FEE SCHEDULE LAB	9,898.00	1,243.00
EKG/ECG	214.00	107.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,691.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303.00	197.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,959.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,811.00	163.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,535.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,454.00	7,817.00
RADIOLOGY THERAPEUTIC	1,685.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,782.00	97.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	912.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	224.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	629.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,401.00	12,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,834.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,399.00	0.00			

TOTAL ANCILLARY	69,204.00	29,227.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,204.00	29,227.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	225,367.00	ADJUSTMENTS	4,142.26
COVERED CHARGES	214,319.00	CONTRACTUAL ALLOW	199,852.68
NON-COVERD CHARGES	11,048.00	TOTAL MEDICAID LIAB	14,466.32
		LESS: COB	31.21
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	14,123.11

TOTAL NUMBER OF CLAIMS 235

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,935.00	25.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,298.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,967.00	2,226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,362.00	6,871.00
EKG/ECG	963.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,938.00	272.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,265.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,169.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	290.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,852.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,493.00	1,577.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	77.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,360.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,579.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	214,319.00	11,048.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	214,319.00	11,048.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,394.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,230.00	CONTRACTUAL ALLOW	3,913.37
NON-COVERD CHARGES	164.00	TOTAL MEDICAID LIAB	3,316.63
		LESS: COB	3,307.63
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	449.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,006.00	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	1,000.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,057.00	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	202.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,358.00	136.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	158.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,230.00	164.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,230.00	164.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,025,594.41	ADJUSTMENTS	117,491.64
COVERED CHARGES	4,671,248.52	CONTRACTUAL ALLOW	3,882,684.45
NON-COVERD CHARGES	354,345.89	TOTAL MEDICAID LIAB	788,564.07
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	788,000.07

TOTAL NUMBER OF CLAIMS 141

GEORGIA 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,101.00	6,189.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	368,810.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,677.00	40,235.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,218.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,496.07	FEE SCHEDULE LAB	32,612.00	4,864.00
EKG/ECG	2,782.00	154.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,767.00	1,224.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	494,881.70	148,760.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,535.00	1,113.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,192.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,852.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,084,310.32	53,899.50
RADIOLOGY THERAPEUTIC	486,532.00	6,768.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	312.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,901.00	442.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	673,927.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	121.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	1,205.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	335,289.00	82,603.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,209.00	5,081.00			

TOTAL ANCILLARY	4,671,248.52	354,345.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,671,248.52	354,345.89

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	62,263.00	ADJUSTMENTS	0.00
COVERED CHARGES	62,173.00	CONTRACTUAL ALLOW	6,565.66
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	55,607.34
		LESS: COB	55,592.34
		LESS: COPAYMENT	15.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,100.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	419.00	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	1,093.00	90.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	48,362.00	0.00
RADIOLOGY THERAPEUTIC	7,290.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,909.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	62,173.00	90.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,173.00	90.00

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,173,133.41	ADJUSTMENTS	1,019,789.14
COVERED CHARGES	77,870,895.71	CONTRACTUAL ALLOW	58,561,306.88
NON-COVERD CHARGES	1,302,237.70	TOTAL MEDICAID LIAB	19,309,588.83
		LESS: COB	89,461.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,220,127.39

TOTAL NUMBER OF ADMISSIONS 2,031

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,225	0	10,369,189.00	524,394.00
ROUTINE NURSERY	844	0	1,453,939.00	296,379.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	55.00
TOTAL ROUTINE	8,069	0	11,823,128.00	820,828.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	969	0	3,589,921.00	22,422.00
NICU	273	0	1,031,940.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,242	0	4,621,861.00	22,422.00
TOTAL ACCOMODATIONS	9,311	0	16,444,989.00	843,250.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,215,693.04	15,009.70	OTHER LAB	477,183.00	0.00
MED/SURG SUPPLY	3,572,915.04	27,139.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,783,978.17	20,789.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	995,890.00	810.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,457,845.00	3,291.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	241,233.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,837,478.00	0.00	MRI SERVICES	671,232.00	0.00
IV THERAPY	1,045,466.00	0.00	PROFESSIONAL FEES	0.00	413.00
OPERATING ROOM	6,979,627.00	43,826.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,833,733.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,657,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	281,156.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	534,914.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,632,719.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	417,354.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	554,621.47	0.00	INJECTABLE DRUGS	1,268,716.80	0.00
RADIOLOGY THERAPEUTIC	147,829.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	140,087.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	106,564.27	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	614,120.00	6,484.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,641.00	14,347.00	TRAUMA RESPONSE	0.00	151,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,279,429.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	32,102.00
OTHER IMAGING SERVICE	504,984.00	18,472.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	469,281.00	80,262.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	382,820.00	44,143.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,875,477.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,251.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	329,419.55	0.00			

TOTAL ANCILLARY	61,425,906.71	458,987.70
TOTAL ACCOMODATIONS	16,444,989.00	843,250.00
TOTAL CHARGES	77,870,895.71	1,302,237.70

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 07/01/17 THROUGH 06/30/18
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	2017223069989	07/27/17 - 07/30/17	08/14/17	0.00	1,387.00	0.00	0.00	0.00
615	2017242062025	08/20/17 - 08/23/17	09/04/17	0.00	1,387.00	0.00	0.00	0.00
615	2017251085051	08/23/17 - 08/29/17	09/11/17	0.00	1,387.00	0.00	0.00	0.00
615	2017270070563	09/15/17 - 09/19/17	10/02/17	0.00	1,387.00	0.00	0.00	0.00
615	2017285069837	09/30/17 - 10/04/17	10/16/17	0.00	1,387.00	0.00	0.00	0.00
615	2017356064997	11/28/17 - 12/15/17	01/01/18	0.00	1,387.00	0.00	0.00	0.00
615	2018011081933	12/22/17 - 01/03/18	01/15/18	0.00	1,387.00	0.00	0.00	0.00
615	2018019061575	12/18/17 - 12/21/17	01/22/18	0.00	1,387.00	0.00	0.00	0.00
615	2018025090674	09/04/17 - 09/06/17	01/29/18	0.00	1,387.00	0.00	0.00	0.00
615	2018036028920	01/15/18 - 01/17/18	02/12/18	0.00	1,387.00	0.00	0.00	0.00
618	2018039080960	12/07/17 - 12/22/17	02/12/18	0.00	1,588.00	0.00	0.00	0.00
615	2018057038906	10/09/17 - 10/17/17	03/05/18	0.00	1,387.00	0.00	0.00	0.00
615	2018089049129	03/24/18 - 03/25/18	04/02/18	0.00	1,387.00	0.00	0.00	0.00
615	2018092028232	02/28/18 - 03/04/18	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018092028263	03/12/18 - 03/13/18	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018093083764	09/08/17 - 09/18/17	04/09/18	0.00	1,387.00	0.00	0.00	0.00
615	2018141028188	05/07/18 - 05/08/18	05/28/18	0.00	1,387.00	0.00	0.00	0.00
615	2018143061057	05/10/18 - 05/15/18	05/28/18	0.00	1,387.00	0.00	0.00	0.00
615	2018152080836	05/12/18 - 05/14/18	06/04/18	0.00	1,387.00	0.00	0.00	0.00
615	2018163059588	05/31/18 - 06/06/18	06/18/18	0.00	1,387.00	0.00	0.00	0.00
615	2018228087222	01/25/18 - 02/09/18	08/20/18	0.00	1,387.00	0.00	0.00	0.00
615	2019053080964	07/23/17 - 08/01/17	02/25/19	0.00	1,387.00	0.00	0.00	0.00
615	2019172065431	02/22/18 - 02/24/18	06/24/19	0.00	1,387.00	0.00	0.00	0.00
TOTAL				0.00	32,102.00	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,079,620.48	ADJUSTMENTS	0.00
COVERED CHARGES	1,046,840.48	CONTRACTUAL ALLOW	464,049.91
NON-COVERD CHARGES	32,780.00	TOTAL MEDICAID LIAB	582,790.57
		LESS: COB	582,790.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	62	0	86,345.00	4,307.00
ROUTINE NURSERY	60	0	153,918.00	26,552.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	122	0	240,263.00	30,859.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	11	0	41,107.00	0.00
NICU	50	0	189,000.00	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	61	0	230,107.00	0.00
TOTAL ACCOMODATIONS	183	0	470,370.00	30,859.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179,268.74	0.00	OTHER LAB	3,467.00	0.00
MED/SURG SUPPLY	54,387.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	114,205.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,758.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,522.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,610.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,690.00	0.00	MRI SERVICES	2,112.00	0.00
IV THERAPY	9,535.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,866.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,525.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,435.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,520.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,715.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,223.00	0.00	INJECTABLE DRUGS	3,444.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,103.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,231.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	79.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,767.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,387.00
OTHER IMAGING SERVICE	6,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	976.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,936.00	534.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,268.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	576,470.48	1,921.00
TOTAL ACCOMODATIONS	470,370.00	30,859.00
TOTAL CHARGES	1,046,840.48	32,780.00

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 07/01/17 THROUGH 06/30/18
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	2218117013285	11/18/17 - 12/01/17	04/30/18	0.00	1,387.00	0.00	47,906.54	0.00
TOTAL				0.00	1,387.00	0.00	47,906.54	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,197,500.44	ADJUSTMENTS	1,557,647.75
COVERED CHARGES	32,210,487.55	CONTRACTUAL ALLOW	27,130,989.18
NON-COVERD CHARGES	1,987,012.89	TOTAL MEDICAID LIAB	5,079,498.37
		LESS: COB	40,585.28
		LESS: COPAYMENT	12,881.39
		REIMBURSEMENT	5,026,031.70
		ALL OTHER	4,104,741.47
		FEE SCHEDULE-LAB	511,143.78
		INJECTABLE DRUGS	410,146.45

TOTAL NUMBER OF CLAIMS 11,464

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	521,453.91	0.00	OTHER LAB	353,531.00	1,003.00
MED/SURG SUPPLY	874,434.51	6,509.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,098,883.50	12,882.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,087,383.00	84,810.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,657.00	20,327.00	FEE SCHEDULE LAB	4,566,506.96	278,861.77
EKG/ECG	454,789.00	4,607.00	MRI SERVICES	936,449.00	35,917.00
IV THERAPY	1,514,120.00	135,695.00	PROFESSIONAL FEES	0.00	56.00
OPERATING ROOM	2,569,792.00	165,099.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	166,031.00	34,634.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,230.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	218,936.00	36,759.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,719,935.00	9,737.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	273,833.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,086,155.97	353,328.65
RADIOLOGY THERAPEUTIC	311,310.00	113,603.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,538.00	3,141.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,078.00	4,962.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	210,868.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	151,680.00	23,056.00	TRAUMA RESPONSE	0.00	174,685.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	234,559.38	34,007.17
LITHOTRIPSY	83,908.00	0.00	NO CC/INVALID REV CODE	0.00	1,387.00
OTHER IMAGING SERVICE	1,458,354.00	58,542.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	148,882.00	1,386.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	670,564.00	80,397.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	853,337.00	98,506.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	411,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,240,266.17	2,246.00			

TOTAL ANCILLARY	32,210,487.55	1,987,012.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,210,487.55	1,987,012.89

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 07/01/17 THROUGH 06/30/18
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	2018151084339	04/29/18 - 04/29/18	06/11/18	0.00	1,387.00	0.00	0.00	0.00
TOTAL				0.00	1,387.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	369,967.93	ADJUSTMENTS	0.00
COVERED CHARGES	294,601.58	CONTRACTUAL ALLOW	172,568.19
NON-COVERD CHARGES	75,366.35	TOTAL MEDICAID LIAB	122,033.39
		LESS: COB	121,940.52
		LESS: COPAYMENT	92.87
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,987.23	0.00	OTHER LAB	4,737.00	0.00
MED/SURG SUPPLY	5,689.35	917.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,355.00	3,544.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,359.00	2,547.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,296.00	FEE SCHEDULE LAB	39,304.90	2,456.84
EKG/ECG	5,317.00	0.00	MRI SERVICES	0.00	2,973.00
IV THERAPY	19,334.00	2,150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,256.00	36,362.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,888.00	394.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,875.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,547.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,089.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,917.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,631.77	1,313.35
RADIOLOGY THERAPEUTIC	600.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	994.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,367.00	318.00	TRAUMA RESPONSE	0.00	7,595.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52.18	1,399.99
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,752.00	1,500.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,938.00	6,093.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,039.00	1,966.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,113.15	0.00			

TOTAL ANCILLARY	294,601.58	75,366.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	294,601.58	75,366.35

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	702,922.95	ADJUSTMENTS	712.22
COVERED CHARGES	689,387.23	CONTRACTUAL ALLOW	668,689.43
NON-COVERD CHARGES	13,535.72	TOTAL MEDICAID LIAB	20,697.80
		LESS: COB	0.00
		LESS: COPAYMENT	525.00
		REIMBURSEMENT	20,172.80
		TOTAL NUMBER OF CLAIMS	370

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,517.25	0.00	OTHER LAB	4,196.00	0.00
MED/SURG SUPPLY	10,314.98	340.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,116.00	6,730.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,060.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	102,540.30	4,651.72
EKG/ECG	6,030.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,426.00	645.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,389.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,566.00	181.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	412,435.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,767.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,443.25	778.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	210.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	260.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,966.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,087.45	0.00			

TOTAL ANCILLARY	689,387.23	13,535.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	689,387.23	13,535.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,788.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,307.00	CONTRACTUAL ALLOW	1,167.91
NON-COVERD CHARGES	481.00	TOTAL MEDICAID LIAB	3,139.09
		LESS: COB	3,136.09
		LESS: COPAYMENT	3.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	481.00	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	336.00	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	3,676.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,307.00	481.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,307.00	481.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,111,089.28	ADJUSTMENTS	179,649.01
COVERED CHARGES	3,874,146.44	CONTRACTUAL ALLOW	3,249,203.93
NON-COVERD CHARGES	236,942.84	TOTAL MEDICAID LIAB	624,942.51
		LESS: COB	0.00
		LESS: COPAYMENT	978.20
		REIMBURSEMENT	623,964.31
		TOTAL NUMBER OF CLAIMS	111

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,189.60	0.00	OTHER LAB	1,292.00	0.00
MED/SURG SUPPLY	330,318.83	896.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,962.00	389.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,662.00	1,880.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	140,729.08	3,188.44
EKG/ECG	7,705.00	9,670.00	MRI SERVICES	5,938.00	0.00
IV THERAPY	237,433.00	3,655.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	519,493.00	770.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,052.00	2,493.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,023.00	362.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,858.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,357,745.02	42,069.40
RADIOLOGY THERAPEUTIC	4,917.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,033.00	4,909.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	693,663.91	13,408.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,622.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,556.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	313,924.00	153,253.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,790.00	0.00			

TOTAL ANCILLARY	3,874,146.44	236,942.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,874,146.44	236,942.84

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,641,912.99	ADJUSTMENTS	21,399.53
COVERED CHARGES	3,618,801.02	CONTRACTUAL ALLOW	1,960,582.71
NON-COVERD CHARGES	23,111.97	TOTAL MEDICAID LIAB	1,658,218.31
		LESS: COB	41,475.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,616,742.35

TOTAL NUMBER OF ADMISSIONS 224

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	522	0	383,978.43	8,776.22
ROUTINE NURSERY	54	0	34,527.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	576	0	418,505.93	8,776.22
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	330	0	452,687.84	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	330	0	452,687.84	0.00
TOTAL ACCOMODATIONS	906	0	871,193.77	8,776.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,580.89	0.00	OTHER LAB	24,402.73	0.00
MED/SURG SUPPLY	234,957.07	157.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	597,539.69	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,376.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	211,534.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,051.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,851.98	0.00	MRI SERVICES	26,654.92	0.00
IV THERAPY	29,714.51	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,963.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,991.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144,816.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	571.23	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	139,242.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,627.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	686.33	0.00	INJECTABLE DRUGS	603,366.38	0.00
RADIOLOGY THERAPEUTIC	15,999.89	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,671.47	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,821.97	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	19,648.20	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	773.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,360.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,711.32
OTHER IMAGING SERVICE	17,543.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,887.76	12,467.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,271.87	0.00			
AUDIOLOGY	2,188.90	0.00			
CARDIOLOGY	81,172.23	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,482.66	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	855.64	0.00			

TOTAL ANCILLARY	2,747,607.25	14,335.75
TOTAL ACCOMODATIONS	871,193.77	8,776.22
TOTAL CHARGES	3,618,801.02	23,111.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2018169008705	06/10/18 - 06/10/18	06/25/18	0.00	1,711.32	0.00	0.00	0.00
TOTAL				0.00	1,711.32	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,267.31	ADJUSTMENTS	0.00
COVERED CHARGES	6,266.92	CONTRACTUAL ALLOW	1,253.07
NON-COVERD CHARGES	0.39	TOTAL MEDICAID LIAB	5,013.85
		LESS: COB	5,013.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	2,211.00	0.39
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	2,211.00	0.39
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	2,211.00	0.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	596.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	341.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	351.23	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,441.48	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	325.86	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,055.92	0.00
TOTAL ACCOMODATIONS	2,211.00	0.39
TOTAL CHARGES	6,266.92	0.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,006,077.19	ADJUSTMENTS	210,532.12
COVERED CHARGES	4,482,073.40	CONTRACTUAL ALLOW	3,496,966.12
NON-COVERD CHARGES	524,003.79	TOTAL MEDICAID LIAB	985,107.28
		LESS: COB	2,575.27
		LESS: COPAYMENT	2,947.88
		REIMBURSEMENT	979,584.13
		ALL OTHER	771,787.92
		FEE SCHEDULE-LAB	164,677.39
		INJECTABLE DRUGS	43,118.82

TOTAL NUMBER OF CLAIMS 3,524

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,953.54	749.46	OTHER LAB	28,166.59	811.71
MED/SURG SUPPLY	130,792.85	3,924.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	122.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186,264.35	3,229.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	702,932.03	86,099.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,861.79	5,186.74	FEE SCHEDULE LAB	982,398.88	58,711.28
EKG/ECG	43,439.80	1,120.77	MRI SERVICES	55,759.79	2,724.50
IV THERAPY	77,197.27	9,556.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,035.68	8,032.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,157.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,429.90	4,874.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	326.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	102,005.17	2,926.62	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,014,501.86	23,916.53	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,117.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	197,676.42	34,642.51
RADIOLOGY THERAPEUTIC	335,464.76	196,770.39	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,199.94	1,742.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,955.68	1,083.62	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	542.58	1,649.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,759.97	185.88
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	95,330.35	10,231.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,070.69	13,501.91			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	106,182.75	43,210.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,259.72	2,995.15			
AMBULATORY SURGERY	197.60	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,462.61	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,629.25	6,005.05			

TOTAL ANCILLARY	4,482,073.40	524,003.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,482,073.40	524,003.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,920.08	ADJUSTMENTS	0.00
COVERED CHARGES	21,502.02	CONTRACTUAL ALLOW	10,855.13
NON-COVERD CHARGES	3,418.06	TOTAL MEDICAID LIAB	10,646.89
		LESS: COB	10,631.89
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.45	22.88	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	536.13	64.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	774.14	617.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,009.90	1,181.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,341.94	217.37
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,150.61	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,066.18	41.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	329.33	194.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	328.85	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	747.53	1,078.85			
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	2,852.99	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	145.00	0.00			

TOTAL ANCILLARY	21,502.02	3,418.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,502.02	3,418.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	185,117.27	ADJUSTMENTS	5,810.15
COVERED CHARGES	180,014.36	CONTRACTUAL ALLOW	162,227.89
NON-COVERD CHARGES	5,102.91	TOTAL MEDICAID LIAB	17,786.47
		LESS: COB	30.00
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	17,324.47

TOTAL NUMBER OF CLAIMS 285

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	970.54	62.31	OTHER LAB	404.77	0.00
MED/SURG SUPPLY	1,263.86	26.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,438.98	1,330.33	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,789.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,903.92	1,969.22
EKG/ECG	2,059.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,017.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,392.27	893.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,586.24	25.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,135.60	795.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	180,014.36	5,102.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,014.36	5,102.91

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,472.12	ADJUSTMENTS	5,477.05
COVERED CHARGES	59,046.16	CONTRACTUAL ALLOW	42,615.01
NON-COVERD CHARGES	20,425.96	TOTAL MEDICAID LIAB	16,431.15
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	16,428.15

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	122.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,084.16	19,124.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	900.86	0.00
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	205.85	205.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	755.66	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,723.12	0.00
RADIOLOGY THERAPEUTIC	25,627.69	1,095.83	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	398.46	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	0.00	0.00			

TOTAL ANCILLARY	59,046.16	20,425.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,046.16	20,425.96

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

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	761,418.75	ADJUSTMENTS	0.00
COVERED CHARGES	657,478.73	CONTRACTUAL ALLOW	407,291.11
NON-COVERD CHARGES	103,940.02	TOTAL MEDICAID LIAB	250,187.62
		LESS: COB	320.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	249,866.73

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	188	0	112,800.00	101,229.00
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	188	0	112,800.00	101,229.00
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	188	0	112,800.00	101,229.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,248.70	0.00	OTHER LAB	3,501.00	0.00
MED/SURG SUPPLY	32,189.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	82,951.16	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,983.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,166.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,336.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,321.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,263.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,485.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,672.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,304.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,827.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,160.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	169.54	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	285.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	534.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	72,287.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,579.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,125.76	1,437.42			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,467.00	1,273.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,661.86	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,161.00	0.00			

TOTAL ANCILLARY	544,678.73	2,711.02
TOTAL ACCOMODATIONS	112,800.00	101,229.00
TOTAL CHARGES	657,478.73	103,940.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,827,722.64	ADJUSTMENTS	69,032.34
COVERED CHARGES	1,586,710.62	CONTRACTUAL ALLOW	1,290,095.18
NON-COVERD CHARGES	241,012.02	TOTAL MEDICAID LIAB	296,615.44
		LESS: COB	166.40
		LESS: COPAYMENT	1,032.00
		REIMBURSEMENT	295,417.04
		ALL OTHER	240,391.63
		FEE SCHEDULE-LAB	52,972.32
		INJECTABLE DRUGS	2,053.09

TOTAL NUMBER OF CLAIMS 1,647

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,080.04	6,948.47	OTHER LAB	6,618.00	0.00
MED/SURG SUPPLY	28,776.43	2,936.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,444.78	7,290.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,275.00	13,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,019.35	1,430.22	FEE SCHEDULE LAB	416,015.44	75,024.76
EKG/ECG	18,189.00	1,161.00	MRI SERVICES	38,134.00	0.00
IV THERAPY	80,475.21	19,938.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,047.50	2,084.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,773.00	5,955.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,832.00	1,281.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	457,867.92	12,165.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,080.00	5,680.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,726.32	11,161.31
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	328.29	0.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,775.31	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	640.00	48,367.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,752.56	6,652.41			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,648.00	11,034.16			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,256.78	5,584.62			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,731.00	1,398.00			

TOTAL ANCILLARY	1,586,710.62	241,012.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,586,710.62	241,012.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,233.40	ADJUSTMENTS	0.00
COVERED CHARGES	5,753.36	CONTRACTUAL ALLOW	3,368.78
NON-COVERD CHARGES	1,480.04	TOTAL MEDICAID LIAB	2,384.58
		LESS: COB	2,384.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70.38	63.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	148.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,200.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,124.58	36.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	153.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,283.69	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.99	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,753.36	1,480.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,753.36	1,480.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,346.08	ADJUSTMENTS	3,684.03
COVERED CHARGES	177,768.08	CONTRACTUAL ALLOW	168,493.06
NON-COVERD CHARGES	5,578.00	TOTAL MEDICAID LIAB	9,275.02
		LESS: COB	0.00
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	8,978.02
		TOTAL NUMBER OF CLAIMS	149

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,184.05	362.82	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	352.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,168.24	186.36	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,095.00	1,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,481.72	1,070.82
EKG/ECG	774.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,412.01	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,007.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	106,011.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,890.72	313.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,392.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,768.08	5,578.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,768.08	5,578.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

RESTORATION HEALTHCARE OF COMMERCE, LLC
70 MEDICAL CENTER DR
COMMERCE,GA 30529-1078

PROVIDER NUMBER
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,052.97	ADJUSTMENTS	12,179.44
COVERED CHARGES	113,150.97	CONTRACTUAL ALLOW	71,950.30
NON-COVERD CHARGES	1,902.00	TOTAL MEDICAID LIAB	41,200.67
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	41,200.67

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	26	0	20,692.00	1,902.00
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	20,692.00	1,902.00
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	20,692.00	1,902.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,927.25	0.00	OTHER LAB	499.00	0.00
MED/SURG SUPPLY	713.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,589.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,594.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,788.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	950.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,827.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,950.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,086.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,535.00	0.00			

TOTAL ANCILLARY	92,458.97	0.00
TOTAL ACCOMODATIONS	20,692.00	1,902.00
TOTAL CHARGES	113,150.97	1,902.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	785,239.53	ADJUSTMENTS	59,869.53
COVERED CHARGES	676,216.85	CONTRACTUAL ALLOW	466,395.98
NON-COVERD CHARGES	109,022.68	TOTAL MEDICAID LIAB	209,820.87
		LESS: COB	616.53
		LESS: COPAYMENT	402.00
		REIMBURSEMENT	208,802.34
		ALL OTHER	191,418.82
		FEE SCHEDULE-LAB	16,320.18
		INJECTABLE DRUGS	1,063.34

TOTAL NUMBER OF CLAIMS 813

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,088.72	931.25	OTHER LAB	3,295.00	0.00
MED/SURG SUPPLY	838.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,811.50	6,323.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,551.00	60,153.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,126.75	15,116.50
EKG/ECG	9,570.00	760.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,489.00	1,413.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	338.00	530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291,385.50	5,444.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,555.12	13,205.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,347.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,076.50	2,242.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,447.00	1,447.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,644.00	109.00			

TOTAL ANCILLARY	676,216.85	109,022.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	676,216.85	109,022.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	915.00	ADJUSTMENTS	0.00
COVERED CHARGES	689.00	CONTRACTUAL ALLOW	200.06
NON-COVERD CHARGES	226.00	TOTAL MEDICAID LIAB	488.94
		LESS: COB	488.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	689.00	226.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	689.00	226.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	689.00	226.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,964.90	ADJUSTMENTS	815.14
COVERED CHARGES	26,875.40	CONTRACTUAL ALLOW	23,205.68
NON-COVERD CHARGES	1,089.50	TOTAL MEDICAID LIAB	3,669.72
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	3,564.72
		TOTAL NUMBER OF CLAIMS	60

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397.15	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	978.00	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	4,281.00	1,006.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	574.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	20,452.00	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	193.25	83.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,875.40	1,089.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,875.40	1,089.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	722.25	ADJUSTMENTS	0.00
COVERED CHARGES	722.25	CONTRACTUAL ALLOW	267.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	454.38
		LESS: COB	451.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	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	538.00	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	161.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	722.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	722.25	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EAST 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,761,983.58	ADJUSTMENTS	300,683.85
COVERED CHARGES	33,960,897.05	CONTRACTUAL ALLOW	27,636,535.11
NON-COVERD CHARGES	801,086.53	TOTAL MEDICAID LIAB	6,324,361.94
		LESS: COB	37,644.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,286,717.77

TOTAL NUMBER OF ADMISSIONS 690

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	966	0	655,907.00	516,776.00
ROUTINE NURSERY	238	0	176,308.00	138,267.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,204	0	832,215.00	655,043.00
SPECIAL CARE SERVICES				
CCU	336	0	632,628.00	0.00
ICU	1,604	0	2,757,716.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,940	0	3,390,344.00	0.00
TOTAL ACCOMODATIONS	3,144	0	4,222,559.00	655,043.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,306,281.55	0.00	OTHER LAB	95,311.79	0.00
MED/SURG SUPPLY	1,200,719.76	620.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,191,398.58	0.00	EDUCATION & TRAINING	7,014.56	0.00
RADIOLOGY-DIAGNOSTIC	819,241.40	3,768.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,652,186.49	11,934.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	313,764.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	124,757.17	0.00	MRI SERVICES	270,349.18	0.00
IV THERAPY	170.72	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,416,725.66	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	416,651.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,841,621.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	714,020.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	332,981.81	9,860.59	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,263,774.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	232,993.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	220,590.68	0.00	INJECTABLE DRUGS	2,602,563.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,424.17	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,876.46	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	131,210.23	1,233.27	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,540.47	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,440,296.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	56,236.56
OTHER IMAGING SERVICE	127,514.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	157,771.48	53,882.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,892.03	8,508.48			
AUDIOLOGY	41,956.15	0.00			
CARDIOLOGY	1,559,431.93	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,444.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	94,861.22	0.00			

TOTAL ANCILLARY	29,738,338.05	146,043.53
TOTAL ACCOMODATIONS	4,222,559.00	655,043.00
TOTAL CHARGES	33,960,897.05	801,086.53

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 10/01/17 THROUGH 09/30/18
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	5018023957033	12/21/17 - 12/24/17	01/29/18	0.00	1,817.34	0.00	0.00	0.00
615	2018052022847	02/09/18 - 02/10/18	02/26/18	0.00	3,522.36	0.00	0.00	0.00
615	2018057024288	02/11/18 - 02/19/18	03/05/18	0.00	3,522.36	0.00	0.00	0.00
615	2018079042137	10/04/17 - 10/06/17	03/26/18	0.00	3,522.36	0.00	0.00	0.00
615	2018093067720	03/20/18 - 03/22/18	04/09/18	0.00	3,522.36	0.00	0.00	0.00
615	2018142060119	05/08/18 - 05/17/18	05/28/18	0.00	8,254.00	0.00	0.00	0.00
615	2218151006155	02/15/18 - 02/20/18	06/04/18	0.00	3,522.36	0.00	0.00	0.00
615	2018162009261	06/01/18 - 06/02/18	06/18/18	0.00	8,254.00	0.00	0.00	0.00
614	2218187011507	03/10/18 - 03/22/18	07/09/18	0.00	1,833.06	0.00	0.00	0.00
615	2018199041694	07/12/18 - 07/13/18	07/23/18	0.00	3,698.00	0.00	0.00	0.00
615	2018247055738	08/27/18 - 08/28/18	09/10/18	0.00	3,698.00	0.00	0.00	0.00
614	2218250007587	07/31/18 - 08/18/18	09/17/18	0.00	3,850.00	0.00	0.00	0.00
615	2018331045781	04/14/18 - 04/20/18	12/03/18	0.00	3,522.36	0.00	0.00	0.00
615	2319122000267	07/16/18 - 07/26/18	05/13/19	0.00	3,698.00	0.00	3,500.74	0.00
TOTAL				0.00	56,236.56	0.00	3,500.74	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	88,632.90	ADJUSTMENTS	0.00
COVERED CHARGES	85,358.90	CONTRACTUAL ALLOW	61,491.17
NON-COVERD CHARGES	3,274.00	TOTAL MEDICAID LIAB	23,867.73
		LESS: COB	23,867.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	3,972.00	3,274.00
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	3,972.00	3,274.00
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	3,972.00	3,274.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,197.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,464.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,211.68	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	579.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,146.92	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	678.43	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	35,620.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	511.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,061.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,753.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,126.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	308.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	378.53	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,350.92	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	81,386.90	0.00
TOTAL ACCOMODATIONS	3,972.00	3,274.00
TOTAL CHARGES	85,358.90	3,274.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,453,138.67	ADJUSTMENTS	684,115.42
COVERED CHARGES	27,084,253.95	CONTRACTUAL ALLOW	25,167,016.11
NON-COVERD CHARGES	2,368,884.72	TOTAL MEDICAID LIAB	1,917,237.84
		LESS: COB	36,356.59
		LESS: COPAYMENT	4,337.05
		REIMBURSEMENT	1,876,544.20
		ALL OTHER	1,708,481.69
		FEE SCHEDULE-LAB	139,268.19
		INJECTABLE DRUGS	28,794.32

TOTAL NUMBER OF CLAIMS 4,586

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840,223.12	584.88	OTHER LAB	578,638.52	15,826.25
MED/SURG SUPPLY	704,308.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,179.90	EDUCATION & TRAINING	0.00	2,919.21
RADIOLOGY-DIAGNOSTIC	953,705.22	114,570.98	OTHER THERAPEUTIC SVC	0.00	30,554.93
CT SCAN	2,782,217.14	235,662.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	13,365.19	FEE SCHEDULE LAB	3,238,175.86	131,660.49
EKG/ECG	129,904.20	6,612.30	MRI SERVICES	680,542.26	62,164.80
IV THERAPY	18,888.30	10,854.61	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,845,716.38	521,344.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,833.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	346,844.82	92,466.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	696,344.71	10,553.64	AMBULANCE	0.00	0.00
GI SERVICES	890,759.76	111,925.84	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,458,366.48	96,944.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	591,270.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	871,122.07	275,460.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,147.41	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	505.44	6,823.91	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	74,082.55	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	59,711.43	7,895.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	333,816.29	87,014.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,861.28
OTHER IMAGING SERVICE	562,141.41	95,231.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,816.35	7,195.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	149,241.27	44,808.79			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,660,585.30	212,687.72			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,773.92	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	650,801.75	87,484.18			

TOTAL ANCILLARY	27,084,253.95	2,368,884.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,084,253.95	2,368,884.72

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 10/01/17 THROUGH 09/30/18
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	5918052000764	12/27/17 - 12/27/17	02/26/18	0.00	3,522.36	0.00	0.00	0.00
614	5918103000202	03/30/18 - 03/30/18	04/16/18	0.00	4,338.92	0.00	0.00	0.00
TOTAL				0.00	7,861.28	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	556,565.09	ADJUSTMENTS	0.00
COVERED CHARGES	391,465.73	CONTRACTUAL ALLOW	213,103.67
NON-COVERD CHARGES	165,099.36	TOTAL MEDICAID LIAB	178,362.06
		LESS: COB	178,321.74
		LESS: COPAYMENT	40.32
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,230.74	0.00	OTHER LAB	19,339.62	1,344.00
MED/SURG SUPPLY	442.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	73.01
RADIOLOGY-DIAGNOSTIC	14,411.75	1,747.70	OTHER THERAPEUTIC SVC	0.00	3,218.44
CT SCAN	17,705.00	40,694.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,692.26	1,812.60
EKG/ECG	2,275.10	213.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,226.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,515.00	36,732.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,062.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,078.01	1,190.42	AMBULANCE	0.00	0.00
GI SERVICES	0.00	17,036.57	CAST ROOM	0.00	0.00
EMERGENCY ROOM	152,977.47	1,233.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,166.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,153.47	4,178.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	505.47	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,615.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,661.44	16,455.64			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	32,984.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,527.79	2,064.37			

TOTAL ANCILLARY	391,465.73	165,099.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	391,465.73	165,099.36

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,568,380.48	ADJUSTMENTS	10,514.42
COVERED CHARGES	2,512,516.97	CONTRACTUAL ALLOW	2,475,414.72
NON-COVERD CHARGES	55,863.51	TOTAL MEDICAID LIAB	37,102.25
		LESS: COB	93.10
		LESS: COPAYMENT	1,047.00
		REIMBURSEMENT	35,962.15

TOTAL NUMBER OF CLAIMS 635

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,545.13	0.00	OTHER LAB	21,230.33	5,248.90
MED/SURG SUPPLY	28,364.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,121.28	4,144.62	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	255,602.96	10,021.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	295,992.42	9,460.57
EKG/ECG	9,981.50	426.00	MRI SERVICES	5,473.00	0.00
IV THERAPY	1,059.00	282.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,148.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,564.20	1,284.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,353.16	4,762.56	AMBULANCE	0.00	0.00
GI SERVICES	5,075.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,557,656.13	4,744.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,525.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,464.27	3,291.50
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	138.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,807.21	6,708.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,350.92			
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	5,552.76	0.00			

TOTAL ANCILLARY	2,512,516.97	55,863.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,512,516.97	55,863.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,857.45	ADJUSTMENTS	0.00
COVERED CHARGES	88,420.32	CONTRACTUAL ALLOW	60,881.71
NON-COVERD CHARGES	9,437.13	TOTAL MEDICAID LIAB	27,538.61
		LESS: COB	27,508.61
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,954.32	325.73	OTHER LAB	5,121.80	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	1,822.95	535.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,504.00	5,416.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,509.65	490.46
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	346.00	385.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	48,926.32	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	3,758.20	71.40
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,477.08	2,212.70			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	88,420.32	9,437.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,420.32	9,437.13

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,316,531.34	ADJUSTMENTS	110,779.29
COVERED CHARGES	2,199,046.98	CONTRACTUAL ALLOW	2,071,506.68
NON-COVERD CHARGES	117,484.36	TOTAL MEDICAID LIAB	127,540.30
		LESS: COB	0.00
		LESS: COPAYMENT	137.32
		REIMBURSEMENT	127,402.98

TOTAL NUMBER OF CLAIMS 23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,562.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	275,739.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	77.00
RADIOLOGY-DIAGNOSTIC	6,704.38	11,882.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	378.52	4,737.56	FEE SCHEDULE LAB	19,680.47	784.08
EKG/ECG	426.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,547.34	196.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,024,153.50	23,602.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,355.26	7,593.94	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,260.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,040.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200,730.96	9,834.14
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	245.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	280,752.25	58,530.41
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	71,383.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,332.61	0.00			

TOTAL ANCILLARY	2,199,046.98	117,484.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,199,046.98	117,484.36

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,919,592.44	ADJUSTMENTS	1,762,049.74
COVERED CHARGES	94,226,928.02	CONTRACTUAL ALLOW	68,854,176.85
NON-COVERD CHARGES	5,692,664.42	TOTAL MEDICAID LIAB	25,372,751.17
		LESS: COB	416,438.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,956,312.77

TOTAL NUMBER OF ADMISSIONS 3,344

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,828	0	13,394,807.00	4,114,996.00
ROUTINE NURSERY	4,864	0	8,852,473.00	118,986.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,692	0	22,247,280.00	4,233,982.00
SPECIAL CARE SERVICES				
CCU	96	0	419,297.00	0.00
ICU	1,822	0	6,341,589.00	0.00
NICU	189	0	740,776.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	232	0	1,240,040.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,339	0	8,741,702.00	0.00
TOTAL ACCOMODATIONS	16,031	0	30,988,982.00	4,233,982.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,353,754.50	96,039.00	OTHER LAB	716,190.00	1,211.00
MED/SURG SUPPLY	977,397.73	46,094.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,690,041.00	60,754.50	EDUCATION & TRAINING	13,357.00	31.00
RADIOLOGY-DIAGNOSTIC	2,738,957.50	8,932.00	OTHER THERAPEUTIC SVC	5,200.00	0.00
CT SCAN	5,681,124.00	212,419.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	422,920.91	63,002.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	779,584.00	1,756.00	MRI SERVICES	1,017,451.00	9,719.00
IV THERAPY	1,209,826.00	1,490.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,987,002.50	32,242.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,558,490.00	464.00	REHAB THERAPY	572.00	0.00
RESPIRATORY SERVICES	3,679,419.54	25,068.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,005,183.00	4,328.00	AMBULANCE	0.00	0.00
GI SERVICES	393,880.00	1,538.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,524,822.00	5,353.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,628,039.50	6,583.00	DRUG-SPECIFIC/HOME IV	0.00	36,025.00
LABORATORY PATHOLOGIC	509,052.00	0.00	INJECTABLE DRUGS	4,613,699.71	17,213.00
RADIOLOGY THERAPEUTIC	12,317.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195,463.05	37,361.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	143,883.58	9,164.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,111,389.00	194,230.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,336.00	4,751.00	TRAUMA RESPONSE	0.00	245,939.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,598,094.00	832.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	159,924.00
OTHER IMAGING SERVICE	541,942.50	24,599.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	454,153.00	138,766.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	501,369.00	6,650.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,290,587.00	5,496.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	178,090.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	701,358.00	708.00			

TOTAL ANCILLARY	63,237,946.02	1,458,682.42
TOTAL ACCOMODATIONS	30,988,982.00	4,233,982.00
TOTAL CHARGES	94,226,928.02	5,692,664.42

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2017209068361	07/18/17 - 07/21/17	08/07/17	0.00	6,424.00	0.00	0.00	0.00
618	2017209068361	07/18/17 - 07/21/17	08/07/17	0.00	3,249.00	0.00	0.00	0.00
615	2317276000016	08/12/17 - 08/13/17	11/06/17	0.00	4,793.00	0.00	644.79	0.00
615	2017301022426	10/04/17 - 10/19/17	11/06/17	0.00	4,793.00	0.00	0.00	0.00
615	2317303000007	09/16/17 - 09/23/17	12/04/17	0.00	4,793.00	0.00	1,116.82	0.00
615	2317310000036	07/04/17 - 07/06/17	12/04/17	0.00	4,793.00	0.00	0.00	0.00
615	2317310000062	07/10/17 - 07/13/17	12/11/17	0.00	4,793.00	0.00	0.00	0.00
615	2217325003770	10/16/17 - 11/09/17	11/27/17	0.00	4,793.00	0.00	0.00	0.00
615	2317347000011	10/23/17 - 10/25/17	12/25/17	0.00	4,793.00	0.00	647.78	0.00
615	2317353000003	10/17/17 - 10/18/17	01/01/18	0.00	4,793.00	0.00	761.76	0.00
615	2017354003878	07/01/17 - 07/03/17	12/25/17	0.00	4,793.00	0.00	0.00	0.00
615	2217363013521	12/04/17 - 12/12/17	01/01/18	0.00	4,793.00	0.00	0.00	0.00
615	2018008024638	12/29/17 - 12/30/17	01/15/18	0.00	4,793.00	0.00	0.00	0.00
615	2018032061271	01/19/18 - 01/23/18	02/05/18	0.00	4,793.00	0.00	0.00	0.00
615	2318043000051	09/06/17 - 09/08/17	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018045071115	01/14/18 - 01/18/18	02/19/18	0.00	4,793.00	0.00	0.00	0.00
615	2218080009376	02/19/18 - 03/07/18	04/02/18	0.00	2,605.00	0.00	0.00	0.00
615	2318085000140	12/23/17 - 12/27/17	04/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318086000101	01/18/18 - 02/06/18	04/16/18	0.00	4,793.00	0.00	6,393.21	0.00
615	2318094000013	11/16/17 - 12/14/17	04/16/18	0.00	4,793.00	0.00	7,510.67	0.00
615	2318100000085	12/30/17 - 01/09/18	04/30/18	0.00	2,605.00	0.00	0.00	0.00
615	2318100000211	10/27/17 - 11/10/17	04/30/18	0.00	4,793.00	0.00	0.00	0.00
615	2018117070814	12/02/17 - 12/05/17	05/07/18	0.00	4,793.00	0.00	0.00	0.00
615	2018122085174	03/22/18 - 04/13/18	05/07/18	0.00	5,210.00	0.00	0.00	0.00
615	2318131000449	08/16/17 - 08/19/17	05/28/18	0.00	7,398.00	0.00	0.00	0.00
615	2318135000037	04/01/18 - 04/02/18	05/28/18	0.00	2,605.00	0.00	967.69	0.00
615	2318138000136	02/03/18 - 02/04/18	06/04/18	0.00	4,793.00	0.00	0.00	0.00
615	2218150000889	04/03/18 - 04/08/18	06/04/18	0.00	2,605.00	0.00	0.00	0.00
615	2018152088817	05/24/18 - 05/25/18	06/11/18	0.00	4,793.00	0.00	0.00	0.00
615	2018173019627	06/04/18 - 06/05/18	06/25/18	0.00	4,793.00	0.00	0.00	0.00
615	2018183033790	06/20/18 - 06/21/18	07/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318228000295	03/26/18 - 04/09/18	09/10/18	0.00	4,793.00	0.00	0.00	0.00
615	2318257000275	04/21/18 - 05/10/18	10/15/18	0.00	2,605.00	0.00	0.00	0.00
615	5219024000168	12/10/17 - 02/19/18	01/28/19	0.00	4,793.00	0.00	0.00	0.00
615	5219058000054	12/31/17 - 08/03/18	03/04/19	0.00	2,188.00	0.00	0.00	0.00
615	2019218093158	05/22/18 - 05/30/18	08/12/19	0.00	4,793.00	0.00	0.00	0.00
TOTAL				0.00	159,924.00	0.00	18,042.72	0.00

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,388,619.44	ADJUSTMENTS	0.00
COVERED CHARGES	1,353,098.44	CONTRACTUAL ALLOW	580,878.78
NON-COVERD CHARGES	35,521.00	TOTAL MEDICAID LIAB	772,219.66
		LESS: COB	772,219.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	68	0	107,576.00	29,805.00
ROUTINE NURSERY	208	0	422,881.00	2,074.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	276	0	530,457.00	31,879.00
SPECIAL CARE SERVICES				
CCU	2	0	8,814.00	0.00
ICU	32	0	93,433.00	0.00
NICU	14	0	54,908.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	48	0	157,155.00	0.00
TOTAL ACCOMODATIONS	324	0	687,612.00	31,879.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,062.67	0.00	OTHER LAB	9,532.00	0.00
MED/SURG SUPPLY	10,875.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	70,185.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,532.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	532.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,268.00	0.00	MRI SERVICES	13,754.00	0.00
IV THERAPY	1,847.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,230.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,460.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89,100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,422.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,129.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,995.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,222.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,712.00	0.00	INJECTABLE DRUGS	19,206.77	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,576.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	298.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,991.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,626.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,215.00	3,642.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,154.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	131,712.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,853.00	0.00			

TOTAL ANCILLARY	665,486.44	3,642.00
TOTAL ACCOMODATIONS	687,612.00	31,879.00
TOTAL CHARGES	1,353,098.44	35,521.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,759,300.38	ADJUSTMENTS	1,489,315.38
COVERED CHARGES	23,628,385.31	CONTRACTUAL ALLOW	19,022,089.03
NON-COVERD CHARGES	3,130,915.07	TOTAL MEDICAID LIAB	4,606,296.28
		LESS: COB	14,187.48
		LESS: COPAYMENT	10,484.33
		REIMBURSEMENT	4,581,624.47
		ALL OTHER	3,321,039.99
		FEE SCHEDULE-LAB	211,737.09
		INJECTABLE DRUGS	1,048,847.39

TOTAL NUMBER OF CLAIMS 7,996

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,300.00	212.00	OTHER LAB	251,865.00	0.00
MED/SURG SUPPLY	79,268.00	67,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	40.00	508.00
RADIOLOGY-DIAGNOSTIC	1,129,960.00	79,407.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,142,427.00	617,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	90,141.00	6,988.17	FEE SCHEDULE LAB	2,071,618.50	119,898.00
EKG/ECG	456,932.00	1,756.00	MRI SERVICES	402,731.00	134,746.00
IV THERAPY	1,643,480.00	110,212.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,482,710.41	392,816.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,902.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88,416.00	26,863.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	485,632.00	3,282.00	AMBULANCE	0.00	0.00
GI SERVICES	95,544.50	33,853.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,266,005.00	25,303.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	351,760.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	827.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,448,182.90	267,622.23
RADIOLOGY THERAPEUTIC	0.00	6,749.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,842.00	6,864.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,634.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	190,950.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	129,726.00	18,181.00	TRAUMA RESPONSE	0.00	100,802.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,761.00	225,795.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	45,301.00
OTHER IMAGING SERVICE	1,089,255.00	122,460.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,310.00	33,992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	413,486.00	253,802.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	656,536.00	219,454.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,901.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	414,653.00	10,363.00			

TOTAL ANCILLARY	23,628,385.31	3,129,333.07
TOTAL ACCOMODATIONS	0.00	1,582.00
TOTAL CHARGES	23,628,385.31	3,130,915.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017270000877	08/28/17 - 08/28/17	10/02/17	0.00	2,605.00	0.00	0.00	0.00
615	2017270000877	08/28/17 - 08/28/17	10/02/17	0.00	2,188.00	0.00	0.00	0.00
241	5917340000480	08/29/17 - 08/29/17	12/11/17	0.00	397.00	0.00	0.00	0.00
241	5917349002944	09/19/17 - 09/19/17	12/18/17	0.00	397.00	0.00	0.00	0.00
615	5918037000105	09/16/17 - 09/16/17	02/12/18	0.00	2,605.00	0.00	0.00	0.00
615	5918081000157	01/31/18 - 01/31/18	03/26/18	0.00	2,605.00	0.00	0.00	0.00
615	5918081000157	01/31/18 - 01/31/18	03/26/18	0.00	2,188.00	0.00	0.00	0.00
615	2018102084798	03/09/18 - 03/09/18	04/16/18	0.00	2,605.00	0.00	0.00	0.00
615	2018102084798	03/09/18 - 03/09/18	04/16/18	0.00	2,188.00	0.00	0.00	0.00
615	5918116001229	03/08/18 - 03/08/18	04/30/18	0.00	2,605.00	0.00	0.00	0.00
615	5918116001229	03/08/18 - 03/08/18	04/30/18	0.00	2,188.00	0.00	0.00	0.00
242	2218165004531	12/12/17 - 12/12/17	06/18/18	0.00	397.00	0.00	0.00	0.00
615	5918166000111	05/08/18 - 05/08/18	06/18/18	0.00	2,605.00	0.00	0.00	0.00
615	5918166000111	05/08/18 - 05/08/18	06/18/18	0.00	2,188.00	0.00	0.00	0.00
613	5918172001415	01/04/18 - 01/04/18	06/25/18	0.00	4,679.00	0.00	0.00	0.00
615	2018197046158	03/20/18 - 03/20/18	07/23/18	0.00	2,605.00	0.00	0.00	0.00
615	2018197046158	03/20/18 - 03/20/18	07/23/18	0.00	2,188.00	0.00	0.00	0.00
615	5918213000172	04/13/18 - 04/13/18	08/06/18	0.00	2,878.00	0.00	0.00	0.00
615	2218235006963	06/14/18 - 06/14/18	08/27/18	0.00	2,605.00	0.00	0.00	0.00
615	2218235006963	06/14/18 - 06/14/18	08/27/18	0.00	2,188.00	0.00	0.00	0.00
242	5918248000361	06/12/18 - 06/12/18	09/10/18	0.00	397.00	0.00	0.00	0.00
TOTAL				0.00	45,301.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	518,390.52	ADJUSTMENTS	0.00
COVERED CHARGES	283,278.50	CONTRACTUAL ALLOW	51,646.74
NON-COVERD CHARGES	235,112.02	TOTAL MEDICAID LIAB	231,631.76
		LESS: COB	231,494.10
		LESS: COPAYMENT	137.66
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	102

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,583.00	0.00	OTHER LAB	13,495.00	0.00
MED/SURG SUPPLY	2,486.00	23,053.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	78.00
RADIOLOGY-DIAGNOSTIC	15,612.00	11,722.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,461.00	50,425.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,606.00	762.02	FEE SCHEDULE LAB	32,646.00	1,743.00
EKG/ECG	7,463.00	439.00	MRI SERVICES	0.00	6,467.00
IV THERAPY	17,338.00	3,480.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,826.00	93,297.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,586.00	2,166.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,669.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	433.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,773.00	372.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,827.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,883.50	3,862.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,601.00	224.00	TRAUMA RESPONSE	0.00	5,355.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,226.00	3,352.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,251.00	5,182.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,014.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,721.00	22,441.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,336.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,442.00	692.00			

TOTAL ANCILLARY	283,278.50	235,112.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	283,278.50	235,112.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,127,227.00	ADJUSTMENTS	1,565.26
COVERED CHARGES	1,053,630.00	CONTRACTUAL ALLOW	1,021,688.26
NON-COVERD CHARGES	73,597.00	TOTAL MEDICAID LIAB	31,941.74
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	31,206.74

TOTAL NUMBER OF CLAIMS 571

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,610.00	0.00	OTHER LAB	5,145.00	0.00
MED/SURG SUPPLY	917.00	1,433.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,548.00	3,557.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	134,081.00	27,990.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	154,125.00	3,120.00
EKG/ECG	15,365.00	0.00	MRI SERVICES	19,165.00	0.00
IV THERAPY	66,178.00	2,451.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,377.00	13,912.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,029.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	522,861.00	581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,292.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,653.00	2,755.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,976.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,346.00	13,552.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,200.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,500.00	1,270.00			

TOTAL ANCILLARY	1,053,630.00	73,597.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,053,630.00	73,597.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,021.00	ADJUSTMENTS	0.00
COVERED CHARGES	54,170.00	CONTRACTUAL ALLOW	25,153.99
NON-COVERD CHARGES	13,851.00	TOTAL MEDICAID LIAB	29,016.01
		LESS: COB	29,001.01
		LESS: COPAYMENT	15.00
		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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,175.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,302.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,445.00	11,994.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,360.00	116.00
EKG/ECG	439.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,884.00	302.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,892.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,756.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,402.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,177.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,107.00	803.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	636.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,149.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	54,170.00	13,851.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	54,170.00	13,851.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,071,477.79	ADJUSTMENTS	387,041.12
COVERED CHARGES	4,440,513.69	CONTRACTUAL ALLOW	3,422,032.71
NON-COVERD CHARGES	630,964.10	TOTAL MEDICAID LIAB	1,018,480.98
		LESS: COB	2,450.50
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	1,015,493.48

TOTAL NUMBER OF CLAIMS 184

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,808.00	0.00	OTHER LAB	5,453.00	0.00
MED/SURG SUPPLY	16,178.00	54,689.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,078.00	16,948.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,064.00	5,204.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,304.00	9,524.00
EKG/ECG	4,829.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	178,728.00	19,944.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	229,905.00	10,105.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,505.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,493.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,235.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,663,832.69	433,393.10
RADIOLOGY THERAPEUTIC	241.00	1,191.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,301.00	36,555.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,520.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,476.00	3,316.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	114,669.00	40,095.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,854.00	0.00			

TOTAL ANCILLARY	4,440,513.69	630,964.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,440,513.69	630,964.10

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

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,016,220.60	ADJUSTMENTS	279,662.51
COVERED CHARGES	44,914,092.45	CONTRACTUAL ALLOW	31,107,865.50
NON-COVERD CHARGES	2,102,128.15	TOTAL MEDICAID LIAB	13,806,226.95
		LESS: COB	192,743.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,613,483.36

TOTAL NUMBER OF ADMISSIONS 1,619

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,760	0	5,005,936.19	143,056.76
ROUTINE NURSERY	1,111	0	1,801,547.28	2,234.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,871	0	6,807,483.47	145,290.76
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	966	0	2,678,140.65	0.00
NICU	28	0	91,616.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	994	0	2,769,756.65	0.00
TOTAL ACCOMODATIONS	6,865	0	9,577,240.12	145,290.76

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,547,142.00	0.00	OTHER LAB	325,620.28	0.00
MED/SURG SUPPLY	2,554,396.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,807,315.55	0.00	EDUCATION & TRAINING	44,567.11	0.00
RADIOLOGY-DIAGNOSTIC	814,556.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,695,479.28	1,350,413.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	234,138.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	406,729.04	0.00	MRI SERVICES	623,754.07	0.00
IV THERAPY	118,625.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,937,521.39	66,681.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	663,458.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,637,510.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	606,647.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	302,031.79	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,842,252.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,673.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	260,694.87	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	68,400.60	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	135,045.74	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	276,437.24	4,503.55	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63,963.03	409.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,084,156.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	352,408.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	447,320.33	33,622.44			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	618,566.20	106,367.63			
AUDIOLOGY	28,311.00	394,839.08			
CARDIOLOGY	2,260,643.91	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,141.88	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215,342.82	0.00			

TOTAL ANCILLARY	35,336,852.33	1,956,837.39
TOTAL ACCOMODATIONS	9,577,240.12	145,290.76
TOTAL CHARGES	44,914,092.45	2,102,128.15

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	280,783.68	ADJUSTMENTS	0.00
COVERED CHARGES	280,693.68	CONTRACTUAL ALLOW	234,695.18
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	45,998.50
		LESS: COB	45,998.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,411.74	90.00
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	5,411.74	90.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	5,444.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	5,444.00	0.00
TOTAL ACCOMODATIONS	7	0	10,855.74	90.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,650.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	68,966.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,908.32	0.00	EDUCATION & TRAINING	185.85	0.00
RADIOLOGY-DIAGNOSTIC	9,101.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,214.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	335.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,306.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	410.55	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,002.35	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	808.08	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,627.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,096.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	20,700.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	130,343.45	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	0.00	0.00			

TOTAL ANCILLARY	269,837.94	0.00
TOTAL ACCOMODATIONS	10,855.74	90.00
TOTAL CHARGES	280,693.68	90.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,534,319.90	ADJUSTMENTS	425,071.86
COVERED CHARGES	16,750,867.04	CONTRACTUAL ALLOW	14,538,995.96
NON-COVERD CHARGES	1,783,452.86	TOTAL MEDICAID LIAB	2,211,871.08
		LESS: COB	5,965.19
		LESS: COPAYMENT	3,300.60
		REIMBURSEMENT	2,202,605.29
		ALL OTHER	2,027,143.90
		FEE SCHEDULE-LAB	153,320.98
		INJECTABLE DRUGS	22,140.41

TOTAL NUMBER OF CLAIMS 4,324

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,659.69	24,837.94	OTHER LAB	387,527.67	8,487.53
MED/SURG SUPPLY	362,351.46	34,433.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	198.79	0.00
RADIOLOGY-DIAGNOSTIC	626,224.78	68,778.73	OTHER THERAPEUTIC SVC	0.00	5,913.08
CT SCAN	1,987,211.82	409,338.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,861.34	19,819.80	FEE SCHEDULE LAB	4,241,425.51	372,544.09
EKG/ECG	199,220.52	27,313.04	MRI SERVICES	132,961.68	14,519.40
IV THERAPY	181,778.30	38,258.93	PROFESSIONAL FEES	0.00	44.10
OPERATING ROOM	1,363,781.70	236,843.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,492.17	1,336.90	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	195,934.90	48,075.73	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	239,801.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	197,934.88	40,208.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,880,953.14	184,205.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,498.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272,030.06	41,348.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,858.13	3,824.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,555.78	969.13	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,729.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,641.10	9,162.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69,322.39	8,165.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	666,386.01	74,886.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,552.87	1,203.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,702.30	47,141.65			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	180,964.54	36,427.05			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,053.21	0.00			
ORGAN ACQUISITION	0.00	10,462.29			
TREATMENT/OBSERV. RM	60,982.31	9,174.35			

TOTAL ANCILLARY	16,750,867.04	1,783,452.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,750,867.04	1,783,452.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,634.09	ADJUSTMENTS	0.00
COVERED CHARGES	11,109.50	CONTRACTUAL ALLOW	7,854.84
NON-COVERD CHARGES	2,524.59	TOTAL MEDICAID LIAB	3,254.66
		LESS: COB	3,254.66
		LESS: COPAYMENT	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	953.24	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	870.57	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	1,323.64	222.11
EKG/ECG	693.32	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,284.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,196.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,834.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238.04	18.14
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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,109.50	2,524.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,109.50	2,524.59

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,410.38	ADJUSTMENTS	3,488.89
COVERED CHARGES	205,823.10	CONTRACTUAL ALLOW	196,850.18
NON-COVERD CHARGES	3,587.28	TOTAL MEDICAID LIAB	8,972.92
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	8,783.92
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.11	7.04	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	5,578.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,594.31	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,268.66	2,703.89
EKG/ECG	2,056.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	141,421.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	461.04	66.62
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,149.38	809.73			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	205,823.10	3,587.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,823.10	3,587.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,709.87	ADJUSTMENTS	0.00
COVERED CHARGES	5,594.96	CONTRACTUAL ALLOW	4,539.02
NON-COVERD CHARGES	8,114.91	TOTAL MEDICAID LIAB	1,055.94
		LESS: COB	1,052.94
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	308.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	142.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	467.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,033.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,345.09	81.84
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	853.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,477.78	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,594.96	8,114.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,594.96	8,114.91

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,967,593.78	ADJUSTMENTS	72,048.99
COVERED CHARGES	1,607,936.44	CONTRACTUAL ALLOW	1,428,784.55
NON-COVERD CHARGES	359,657.34	TOTAL MEDICAID LIAB	179,151.89
		LESS: COB	5,752.00
		LESS: COPAYMENT	95.60
		REIMBURSEMENT	173,304.29

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,845.62	1,881.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	254,776.60	36,083.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,794.60	15,798.26	OTHER THERAPEUTIC SVC	0.00	447.74
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,360.51	4,963.06
EKG/ECG	1,409.96	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,247.24	7,391.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	916,090.18	153,374.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,562.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,935.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,529.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,655.07	7,887.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	135,089.68	50,863.33
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,863.75	2,403.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,012.85	417.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,888.81	78,145.89			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,785.80	0.00			

TOTAL ANCILLARY	1,607,936.44	359,657.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,607,936.44	359,657.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,940.97	ADJUSTMENTS	0.00
COVERED CHARGES	162,005.97	CONTRACTUAL ALLOW	43,837.91
NON-COVERD CHARGES	1,935.00	TOTAL MEDICAID LIAB	118,168.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	118,168.06

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	20,000.00	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	50	0	20,000.00	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	50	0	20,000.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,332.91	0.00	OTHER LAB	327.00	0.00
MED/SURG SUPPLY	16,035.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,332.39	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,317.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,635.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,378.00	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	4,800.00	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	3,240.00	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	123.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	513.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,576.00	1,935.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,166.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	230.00	0.00			

TOTAL ANCILLARY	142,005.97	1,935.00
TOTAL ACCOMODATIONS	20,000.00	0.00
TOTAL CHARGES	162,005.97	1,935.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	513,525.17	ADJUSTMENTS	12,907.09
COVERED CHARGES	479,381.33	CONTRACTUAL ALLOW	182,629.70
NON-COVERD CHARGES	34,143.84	TOTAL MEDICAID LIAB	296,751.63
		LESS: COB	0.00
		LESS: COPAYMENT	582.00
		REIMBURSEMENT	296,169.63
		ALL OTHER	274,233.73
		FEE SCHEDULE-LAB	21,935.90
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 652

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,618.18	227.60	OTHER LAB	2,386.00	214.00
MED/SURG SUPPLY	23,721.12	519.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,127.00	4,223.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,529.50	5,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,526.00	360.00	FEE SCHEDULE LAB	170,542.53	9,066.00
EKG/ECG	14,811.00	2,945.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	38.00
OPERATING ROOM	5,481.00	1,006.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,137.00	364.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,741.00	6,055.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	896.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,137.00	570.00			
BLOOD	0.00	0.00			
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	1,083.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,240.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,405.00	1,521.00			

TOTAL ANCILLARY	479,381.33	34,143.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	479,381.33	34,143.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	621.66	ADJUSTMENTS	0.00
COVERED CHARGES	529.57	CONTRACTUAL ALLOW	28.28
NON-COVERD CHARGES	92.09	TOTAL MEDICAID LIAB	501.29
		LESS: COB	501.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.67	92.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	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	200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	529.57	92.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	529.57	92.09

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,734.45	ADJUSTMENTS	141.00
COVERED CHARGES	32,880.31	CONTRACTUAL ALLOW	29,430.31
NON-COVERD CHARGES	854.14	TOTAL MEDICAID LIAB	3,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	3,336.00
		TOTAL NUMBER OF CLAIMS	69

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,595.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	760.89	51.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,849.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,765.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,058.40	758.00
EKG/ECG	486.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,366.00	45.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,880.31	854.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,880.31	854.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,791.52	ADJUSTMENTS	5,785.12
COVERED CHARGES	22,698.52	CONTRACTUAL ALLOW	5,343.16
NON-COVERD CHARGES	1,093.00	TOTAL MEDICAID LIAB	17,355.36
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,355.36
		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

CLINCH MEMORIAL HOSP
1050 VALDOSTA HWY
HOMERVILLE,GA 31634-9701

PROVIDER NUMBER
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,087.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,617.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,866.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,274.00	90.00
EKG/ECG	751.00	530.00	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	64.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,294.00	293.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,511.00	180.00			

TOTAL ANCILLARY	22,698.52	1,093.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,698.52	1,093.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,027,681.07	ADJUSTMENTS	3,136,531.05
COVERED CHARGES	86,873,670.82	CONTRACTUAL ALLOW	69,579,473.65
NON-COVERD CHARGES	6,154,010.25	TOTAL MEDICAID LIAB	17,294,197.17
		LESS: COB	172,414.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,121,782.93

TOTAL NUMBER OF ADMISSIONS 2,124

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,053	0	7,726,772.00	2,017,190.00
ROUTINE NURSERY	1,463	0	2,035,411.00	30,002.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,516	0	9,762,183.00	2,047,192.00
SPECIAL CARE SERVICES				
CCU	2,344	0	5,736,636.00	170,309.00
ICU	958	0	3,498,398.00	241,248.00
NICU	526	0	1,801,682.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	228	0	468,582.00	759,426.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,056	0	11,505,298.00	1,170,983.00
TOTAL ACCOMODATIONS	11,572	0	21,267,481.00	3,218,175.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,658,531.30	519,349.15	OTHER LAB	672,856.99	61,590.50
MED/SURG SUPPLY	2,386,819.29	135,728.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,769,333.29	355,334.00	EDUCATION & TRAINING	55,086.00	0.00
RADIOLOGY-DIAGNOSTIC	1,548,652.00	101,109.00	OTHER THERAPEUTIC SVC	0.00	49,118.00
CT SCAN	4,507,165.37	95,678.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	463,378.78	50,002.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	663,573.00	12,725.50	MRI SERVICES	1,020,666.00	32,651.00
IV THERAPY	1,048,469.00	18,631.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,864,387.26	209,116.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,148,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,430,268.71	667,133.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,488,534.55	70,125.00	AMBULANCE	0.00	0.00
GI SERVICES	71,475.00	5,080.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,884,622.00	7,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,053,346.00	10,158.43	DRUG-SPECIFIC/HOME IV	0.00	17,242.00
LABORATORY PATHOLOGIC	414,787.21	11,149.00	INJECTABLE DRUGS	18,686.29	0.00
RADIOLOGY THERAPEUTIC	77,973.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	313,105.79	25,122.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	196,039.89	33,399.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,030,612.00	102,084.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51,075.00	8,645.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	280,483.00	0.00	IMPL DEV CHARGE PATIENTS	1,455,208.55	134,636.36
LITHOTRIPSY	39,464.00	0.00	NO CC/INVALID REV CODE	0.00	157.00
OTHER IMAGING SERVICE	654,797.42	2,570.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,116,718.00	172,783.07			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	504,059.23	6,152.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,920,517.81	9,637.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	181,955.00	3,444.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	614,823.09	8,158.23			

TOTAL ANCILLARY	65,606,189.82	2,935,835.25
TOTAL ACCOMODATIONS	21,267,481.00	3,218,175.00
TOTAL CHARGES	86,873,670.82	6,154,010.25

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 07/01/17 THROUGH 06/30/18
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	2018114061288	02/24/18 - 03/09/18	04/30/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	157.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,109,604.95	ADJUSTMENTS	0.00
COVERED CHARGES	1,103,052.95	CONTRACTUAL ALLOW	575,068.52
NON-COVERD CHARGES	6,552.00	TOTAL MEDICAID LIAB	527,984.43
		LESS: COB	527,984.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	117	0	151,164.00	6,552.00
ROUTINE NURSERY	30	0	18,564.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	147	0	169,728.00	6,552.00
SPECIAL CARE SERVICES				
CCU	13	0	32,682.00	0.00
ICU	1	0	3,591.00	0.00
NICU	2	0	6,844.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	43,117.00	0.00
TOTAL ACCOMODATIONS	163	0	212,845.00	6,552.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,759.50	0.00	OTHER LAB	8,485.00	0.00
MED/SURG SUPPLY	37,378.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	96,957.00	0.00	EDUCATION & TRAINING	5,527.00	0.00
RADIOLOGY-DIAGNOSTIC	5,514.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,516.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	872.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,072.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,208.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	109,898.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	360,190.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,767.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,384.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,085.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,206.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	382.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,938.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	999.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,711.59	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,023.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,551.10	0.00			

TOTAL ANCILLARY	890,207.95	0.00
TOTAL ACCOMODATIONS	212,845.00	6,552.00
TOTAL CHARGES	1,103,052.95	6,552.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,312,948.69	ADJUSTMENTS	723,131.79
COVERED CHARGES	28,636,864.27	CONTRACTUAL ALLOW	24,715,649.35
NON-COVERD CHARGES	3,676,084.42	TOTAL MEDICAID LIAB	3,921,214.92
		LESS: COB	47,935.17
		LESS: COPAYMENT	6,838.24
		REIMBURSEMENT	3,866,441.51
		ALL OTHER	3,274,100.64
		FEE SCHEDULE-LAB	353,505.06
		INJECTABLE DRUGS	238,835.81

TOTAL NUMBER OF CLAIMS 8,475

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	905,743.79	919.00	OTHER LAB	660,189.00	5,013.00
MED/SURG SUPPLY	585,671.00	30,609.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	423.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,371,724.00	20,687.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,778,312.00	663,992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,708.00	28,851.00	FEE SCHEDULE LAB	4,507,771.93	264,709.12
EKG/ECG	539,136.00	3,584.00	MRI SERVICES	618,737.00	77,040.00
IV THERAPY	1,865,630.00	91,070.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,588,576.50	431,369.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	102,771.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	116,012.00	120,449.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	750,459.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,250.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,195,904.00	16,792.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	593,319.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,362.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,403,782.99	753,994.00
RADIOLOGY THERAPEUTIC	15,544.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,246.00	9,186.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,624.00	2,269.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	425,148.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69,457.00	21,205.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	179,547.00	108,777.00	IMPL DEV CHARGE PATIENTS	255,737.06	30,324.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	814,161.00	291,437.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	417,399.00	58,284.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	485,157.00	145,712.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	616,827.00	68,878.00			

TOTAL ANCILLARY	28,636,864.27	3,676,084.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,636,864.27	3,676,084.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	531,906.34	ADJUSTMENTS	0.00
COVERED CHARGES	420,851.86	CONTRACTUAL ALLOW	234,572.94
NON-COVERD CHARGES	111,054.48	TOTAL MEDICAID LIAB	186,278.92
		LESS: COB	186,248.92
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 118

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,198.00	510.00	OTHER LAB	19,295.00	0.00
MED/SURG SUPPLY	7,923.41	942.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,132.00	545.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,154.00	34,174.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	71,063.98	5,475.54
EKG/ECG	6,144.00	0.00	MRI SERVICES	0.00	9,467.00
IV THERAPY	32,643.00	3,872.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,686.00	32,829.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,048.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,130.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,865.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124.00	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	111.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	556.00	IMPL DEV CHARGE PATIENTS	7,996.97	331.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,574.00	17,222.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,465.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,700.00	282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,078.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,054.50	4,848.00			

TOTAL ANCILLARY	420,851.86	111,054.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	420,851.86	111,054.48

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	884,483.12	ADJUSTMENTS	929.98
COVERED CHARGES	838,408.12	CONTRACTUAL ALLOW	815,790.74
NON-COVERD CHARGES	46,075.00	TOTAL MEDICAID LIAB	22,617.38
		LESS: COB	856.72
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	21,256.66
		TOTAL NUMBER OF CLAIMS	389

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,549.50	0.00	OTHER LAB	20,970.00	0.00
MED/SURG SUPPLY	1,953.62	186.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	189.00
RADIOLOGY-DIAGNOSTIC	52,955.00	3,777.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,247.00	7,654.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	165,747.00	7,521.00
EKG/ECG	11,776.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,282.00	666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,848.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	442,139.00	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	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	5,229.00	7,722.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,176.00	16,129.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	838,408.12	46,075.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	838,408.12	46,075.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,719.75	ADJUSTMENTS	0.00
COVERED CHARGES	19,719.75	CONTRACTUAL ALLOW	14,349.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,370.07
		LESS: COB	5,361.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245.75	0.00	OTHER LAB	1,990.00	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	1,338.00	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	4,084.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	8,857.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,066.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,719.75	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,719.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,681,270.20	ADJUSTMENTS	253,792.07
COVERED CHARGES	5,474,210.28	CONTRACTUAL ALLOW	4,839,485.47
NON-COVERD CHARGES	207,059.92	TOTAL MEDICAID LIAB	634,724.81
		LESS: COB	0.00
		LESS: COPAYMENT	674.05
		REIMBURSEMENT	634,050.76

TOTAL NUMBER OF CLAIMS 117

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,391.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100,354.31	247.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,466.00	545.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,275.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,480.00	38.00
EKG/ECG	1,024.00	512.00	MRI SERVICES	0.00	0.00
IV THERAPY	282,480.00	4,854.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	274,722.50	63,219.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,922.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,848,902.50	78,915.50
RADIOLOGY THERAPEUTIC	9,976.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,281.00	4,844.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	454,900.53	0.00
LITHOTRIPSY	108,773.00	36,857.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,842.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,046.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,671.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,753.19	4,463.00			

TOTAL ANCILLARY	5,474,210.28	207,059.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,474,210.28	207,059.92

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

WELLSTAR COBB HOSPITAL
3950 AUSTELL RD
AUSTELL,GA 30106-1121

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,802,418.87	ADJUSTMENTS	44,401.85
COVERED CHARGES	1,653,379.76	CONTRACTUAL ALLOW	821,604.18
NON-COVERD CHARGES	149,039.11	TOTAL MEDICAID LIAB	831,775.58
		LESS: COB	16,364.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	815,411.09

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	330	0	144,870.00	220.00
ROUTINE NURSERY	73	0	18,537.00	39.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	403	0	163,407.00	259.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	113	0	119,677.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	113	0	119,677.00	0.00
TOTAL ACCOMODATIONS	516	0	283,084.00	259.00

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,504.09	0.00	OTHER LAB	4,371.00	0.00
MED/SURG SUPPLY	29,623.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	298,109.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,637.00	0.00	OTHER THERAPEUTIC SVC	0.00	182.00
CT SCAN	0.00	141,471.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,931.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,493.00	0.00	MRI SERVICES	6,847.00	0.00
IV THERAPY	59,130.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,689.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	80,247.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,072.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,232.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,243.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,359.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,991.00	0.00	INJECTABLE DRUGS	296,386.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,944.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.11
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	146.00	1,136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	89,016.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,565.00
OTHER IMAGING SERVICE	5,880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,765.00	811.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,972.00	1,614.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,214.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,942.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,550.00	0.00			

TOTAL ANCILLARY	1,370,295.76	148,780.11
TOTAL ACCOMODATIONS	283,084.00	259.00
TOTAL CHARGES	1,653,379.76	149,039.11

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2217296004672	09/24/17 - 09/29/17	10/30/17	0.00	2,000.00	0.00	0.00	0.00
614	2018166001059	05/26/18 - 06/04/18	06/18/18	0.00	1,565.00	0.00	0.00	0.00
TOTAL				0.00	3,565.00	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 MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,713,204.82	ADJUSTMENTS	91,661.80
COVERED CHARGES	3,363,349.23	CONTRACTUAL ALLOW	2,500,652.80
NON-COVERD CHARGES	349,855.59	TOTAL MEDICAID LIAB	862,696.43
		LESS: COB	934.35
		LESS: COPAYMENT	1,551.00
		REIMBURSEMENT	860,211.08
		ALL OTHER	764,250.90
		FEE SCHEDULE-LAB	81,326.31
		INJECTABLE DRUGS	14,633.87

TOTAL NUMBER OF CLAIMS 2,237

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,429.58	11,592.17	OTHER LAB	21,055.00	534.00
MED/SURG SUPPLY	14,188.00	359.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	178,736.00	3,566.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	612,510.00	87,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,573.00	11,553.00	FEE SCHEDULE LAB	622,141.00	28,763.00
EKG/ECG	58,338.00	3,281.00	MRI SERVICES	107,392.00	7,281.00
IV THERAPY	238,604.00	33,532.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,047.50	14,207.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	596.00	148.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,338.00	5,572.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	218.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,355.00	13,945.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	813,930.00	17,957.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,214.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	219.00	INJECTABLE DRUGS	152,681.15	32,254.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,440.00	921.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,136.00	3,650.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,183.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,753.00
OTHER IMAGING SERVICE	66,838.00	1,707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,936.00	4,866.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,060.00	44,151.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,618.00	17,765.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,343.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,449.00	193.00			

TOTAL ANCILLARY	3,363,349.23	349,855.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,363,349.23	349,855.59

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017229001644	08/04/17 - 08/04/17	08/21/17	0.00	2,838.00	0.00	0.00	0.00
614	2017333079459	11/10/17 - 11/10/17	12/04/17	0.00	1,915.00	0.00	0.00	0.00
TOTAL				0.00	4,753.00	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

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,850.80	ADJUSTMENTS	0.00
COVERED CHARGES	49,100.40	CONTRACTUAL ALLOW	15,033.83
NON-COVERD CHARGES	14,750.40	TOTAL MEDICAID LIAB	34,066.57
		LESS: COB	34,045.44
		LESS: COPAYMENT	21.13
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	606.30	165.00	OTHER LAB	891.00	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	631.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,098.00	8,552.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,743.00	1,794.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,731.00	0.00
IV THERAPY	2,726.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,260.00	3,274.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	128.00	64.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,285.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	333.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,584.10	175.40
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	142.00	146.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,650.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142.00	0.00			

TOTAL ANCILLARY	49,100.40	14,750.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,100.40	14,750.40

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	205,811.90	ADJUSTMENTS	52.94
COVERED CHARGES	195,994.85	CONTRACTUAL ALLOW	185,198.43
NON-COVERD CHARGES	9,817.05	TOTAL MEDICAID LIAB	10,796.42
		LESS: COB	0.00
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	10,466.42
		TOTAL NUMBER OF CLAIMS	193

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254.85	188.05	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	11,097.00	567.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,373.00	3,936.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,653.00	1,422.00
EKG/ECG	3,281.00	193.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,067.00	879.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,278.00	126.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,068.00	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	6,525.00	1,035.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,398.00	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	1,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	195,994.85	9,817.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	195,994.85	9,817.05

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 PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	701.00	ADJUSTMENTS	0.00
COVERED CHARGES	701.00	CONTRACTUAL ALLOW	224.32
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	476.68
		LESS: COB	476.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	408.00	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	293.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	701.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	701.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARYS SACRED HEART HOSPITAL INC
367 CLEAR CREEK PARKWAY
LAVONIA,GA 30553-4173

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COFFEE REGIONAL MEDICAL CENTER
1101 OCILLA RD
DOUGLAS,GA 31533-2207

PROVIDER NUMBER 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,143,099.04	ADJUSTMENTS	397,480.14
COVERED CHARGES	11,841,511.04	CONTRACTUAL ALLOW	8,332,690.33
NON-COVERD CHARGES	301,588.00	TOTAL MEDICAID LIAB	3,508,820.71
		LESS: COB	79,554.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,429,266.15

TOTAL NUMBER OF ADMISSIONS 406

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,283	0	971,374.00	3,969.00
ROUTINE NURSERY	45	0	32,880.00	28.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,328	0	1,004,254.00	3,997.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	313	0	430,484.00	0.00
NICU	1	0	810.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	314	0	431,294.00	0.00
TOTAL ACCOMODATIONS	1,642	0	1,435,548.00	3,997.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,271,029.53	179.00	OTHER LAB	74,253.00	0.00
MED/SURG SUPPLY	510,976.00	603.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,238,009.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	285,006.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	630,992.00	3,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	105,732.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	301,703.00	0.00	MRI SERVICES	70,017.00	0.00
IV THERAPY	166,025.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,309,732.00	48,718.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,091.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	730,823.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,184.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,661.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	305,412.00	0.00	SPECIAL SERVICES	0.00	258.00
RECOVERY ROOM	47,428.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	122,813.00
LABORATORY PATHOLOGIC	23,187.00	0.00	INJECTABLE DRUGS	159,549.37	0.00
RADIOLOGY THERAPEUTIC	210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,091.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,180.39	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	100,962.00	14,220.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	630.00	1,464.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	839,880.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,504.00
OTHER IMAGING SERVICE	31,493.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,796.00	92,106.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	163,668.00	4,771.00			
AUDIOLOGY	6,344.00	0.00			
CARDIOLOGY	544,669.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,512.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189,716.96	0.00			

TOTAL ANCILLARY	10,405,963.04	297,591.00
TOTAL ACCOMODATIONS	1,435,548.00	3,997.00
TOTAL CHARGES	11,841,511.04	301,588.00

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 01/01/18 THROUGH 12/31/18
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	2018060076270	02/23/18 - 02/24/18	03/05/18	0.00	5,707.00	0.00	0.00	0.00
615	9718285957002	01/10/18 - 02/08/18	10/15/18	0.00	2,797.00	0.00	0.00	0.00
TOTAL				0.00	8,504.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,912.04	ADJUSTMENTS	0.00
COVERED CHARGES	150,643.04	CONTRACTUAL ALLOW	98,682.16
NON-COVERD CHARGES	1,269.00	TOTAL MEDICAID LIAB	51,960.88
		LESS: COB	51,960.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	22	0	16,720.00	198.00
ROUTINE NURSERY	5	0	3,650.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27	0	20,370.00	198.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	4,940.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,940.00	0.00
TOTAL ACCOMODATIONS	31	0	25,310.00	198.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,852.00	0.00	OTHER LAB	810.00	0.00
MED/SURG SUPPLY	10,101.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,188.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,943.00	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	1,877.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	338.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,288.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,808.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,066.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	668.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	273.00	0.00	INJECTABLE DRUGS	2,319.00	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	729.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	862.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	442.00	1,071.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	488.00	0.00			
CARDIOLOGY	39,430.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,893.04	0.00			

TOTAL ANCILLARY	125,333.04	1,071.00
TOTAL ACCOMODATIONS	25,310.00	198.00
TOTAL CHARGES	150,643.04	1,269.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,597,813.96	ADJUSTMENTS	540,672.80
COVERED CHARGES	11,838,050.30	CONTRACTUAL ALLOW	9,909,162.66
NON-COVERD CHARGES	759,763.66	TOTAL MEDICAID LIAB	1,928,887.64
		LESS: COB	31,679.42
		LESS: COPAYMENT	5,508.27
		REIMBURSEMENT	1,891,699.95
		ALL OTHER	1,637,232.41
		FEE SCHEDULE-LAB	158,955.86
		INJECTABLE DRUGS	95,511.68

TOTAL NUMBER OF CLAIMS 4,410

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391,665.00	396.00	OTHER LAB	99,595.00	0.00
MED/SURG SUPPLY	342,836.99	3,530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504,785.98	47,361.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,453,481.00	76,666.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,641.00	3,311.05	FEE SCHEDULE LAB	2,112,660.96	105,063.00
EKG/ECG	218,940.00	200.00	MRI SERVICES	308,678.00	25,419.00
IV THERAPY	525,898.00	154,527.00	PROFESSIONAL FEES	0.00	707.00
OPERATING ROOM	1,266,321.64	39,674.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,152.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	239,398.00	9,286.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	275,881.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	163,929.00	300.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,198,997.09	2,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	16,875.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	483,063.21	75,525.08
RADIOLOGY THERAPEUTIC	15,348.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,571.00	2,677.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,440.00	305.15	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,679.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	127,055.00	5,030.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	147,039.00	2,700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	200,465.99	11,809.02			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,491.00	7,497.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	389,411.00	2,488.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	554,504.00	90,862.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,916.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	678,765.44	65,904.00			

TOTAL ANCILLARY	11,838,050.30	759,667.66
TOTAL ACCOMODATIONS	0.00	96.00
TOTAL CHARGES	11,838,050.30	759,763.66

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	113,312.00	ADJUSTMENTS	0.00
COVERED CHARGES	97,541.97	CONTRACTUAL ALLOW	52,228.71
NON-COVERD CHARGES	15,770.03	TOTAL MEDICAID LIAB	45,313.26
		LESS: COB	45,295.26
		LESS: COPAYMENT	18.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,539.00	0.00	OTHER LAB	640.00	0.00
MED/SURG SUPPLY	5,919.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,719.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,273.00	3,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278.00	446.00	FEE SCHEDULE LAB	24,550.00	1,945.00
EKG/ECG	877.00	0.00	MRI SERVICES	2,702.00	6,920.00
IV THERAPY	6,853.00	676.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,544.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,336.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	816.00	382.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	305.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,518.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,492.97	1,700.00			

TOTAL ANCILLARY	97,541.97	15,770.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	97,541.97	15,770.03

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	400,385.11	ADJUSTMENTS	9,573.18
COVERED CHARGES	368,992.49	CONTRACTUAL ALLOW	341,225.47
NON-COVERD CHARGES	31,392.62	TOTAL MEDICAID LIAB	27,767.02
		LESS: COB	4,092.68
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	23,137.34
		TOTAL NUMBER OF CLAIMS	352

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,277.00	38.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,066.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,937.99	599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,935.00	4,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	96,212.00	4,989.00
EKG/ECG	4,276.99	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,841.00	2,028.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,767.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	152,621.02	1,051.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,606.00	15,633.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,572.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,892.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,110.00	752.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	878.49	1,834.62			

TOTAL ANCILLARY	368,992.49	31,392.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	368,992.49	31,392.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,414.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,993.01	CONTRACTUAL ALLOW	7,264.42
NON-COVERD CHARGES	420.99	TOTAL MEDICAID LIAB	3,728.59
		LESS: COB	3,713.54
		LESS: COPAYMENT	15.05
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	266.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	987.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,828.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,206.98	26.99
EKG/ECG	599.98	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	384.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	427.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,091.05	384.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	138.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,993.01	420.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,993.01	420.99

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,139,997.80	ADJUSTMENTS	193,636.68
COVERED CHARGES	1,930,765.78	CONTRACTUAL ALLOW	1,636,030.48
NON-COVERD CHARGES	209,232.02	TOTAL MEDICAID LIAB	294,735.30
		LESS: COB	56,607.77
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	237,956.53

TOTAL NUMBER OF CLAIMS 44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,941.00	0.00	OTHER LAB	5,245.00	0.00
MED/SURG SUPPLY	118,919.00	65.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,797.00	38,852.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,380.00	1,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,774.00	FEE SCHEDULE LAB	32,750.00	1,472.00
EKG/ECG	4,400.00	400.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,959.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	517,796.00	4,661.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,042.00	1,220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,899.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,635.00	288.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	226,525.03	53,357.02
RADIOLOGY THERAPEUTIC	8,753.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	414,421.00	7,500.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,780.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,721.00	87,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	434,352.75	10,654.00			

TOTAL ANCILLARY	1,930,765.78	209,232.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,930,765.78	209,232.02

GEORGIA DEPARTMENT OF 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,621.01	ADJUSTMENTS	0.00
COVERED CHARGES	72,793.01	CONTRACTUAL ALLOW	-1,560.08
NON-COVERD CHARGES	47,828.00	TOTAL MEDICAID LIAB	74,353.09
		LESS: COB	74,347.09
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	159.00	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	666.00	27.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	730.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,105.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	37,456.01	47,801.00
RADIOLOGY THERAPEUTIC	1,434.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	16,177.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	72,793.01	47,828.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,793.01	47,828.00

** 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 CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,010,470.65	ADJUSTMENTS	2,119,816.78
COVERED CHARGES	69,078,211.88	CONTRACTUAL ALLOW	56,742,832.74
NON-COVERD CHARGES	5,932,258.77	TOTAL MEDICAID LIAB	12,335,379.14
		LESS: COB	72,464.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,262,914.18

TOTAL NUMBER OF ADMISSIONS 1,142

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,419	0	6,745,951.00	4,973,873.00
ROUTINE NURSERY	198	0	592,816.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6,617	0	7,338,767.00	4,973,873.00
SPECIAL CARE SERVICES				
CCU	86	0	357,716.00	0.00
ICU	692	0	2,843,546.00	0.00
NICU	116	0	533,568.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	19	0	79,741.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	29	0	359,166.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	942	0	4,173,737.00	0.00
TOTAL ACCOMODATIONS	7,559	0	11,512,504.00	4,973,873.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,405,267.72	18,967.63	OTHER LAB	424,874.31	0.00
MED/SURG SUPPLY	2,352,194.50	15,425.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,287,367.73	5,661.27	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,160,801.24	0.00	OTHER THERAPEUTIC SVC	0.00	1,100.50
CT SCAN	3,430,044.17	669,702.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,040,939.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	425,101.75	0.00	MRI SERVICES	1,168,304.25	0.00
IV THERAPY	14,871.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,311,059.34	7,343.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	233,021.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,853,166.02	8,244.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,065,376.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	200,014.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,531,914.22	1,414.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	636,802.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	69,314.00
LABORATORY PATHOLOGIC	143,593.07	0.00	INJECTABLE DRUGS	10,270,669.83	13,456.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	851,533.89	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	239,241.88	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	341,414.57	1,317.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,531.25	69.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	728,327.50	0.00
LITHOTRIPSY	9,200.25	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	527,489.19	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	435,447.03	128,282.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	160,172.00	13,996.25			
AUDIOLOGY	243.50	0.00			
CARDIOLOGY	3,223,659.29	4,090.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,716.69	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,346.50	0.00			

TOTAL ANCILLARY	57,565,707.88	958,385.77
TOTAL ACCOMODATIONS	11,512,504.00	4,973,873.00
TOTAL CHARGES	69,078,211.88	5,932,258.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017258066736	08/15/17 - 08/25/17	09/25/17	0.00	0.00	0.00	0.00	0.00
24	2017268029495	09/08/17 - 09/16/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017269069474	09/08/17 - 09/19/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017271078580	09/12/17 - 09/23/17	10/02/17	0.00	0.00	0.00	0.00	0.00
24	2017277080950	09/07/17 - 09/15/17	10/09/17	0.00	0.00	0.00	0.00	0.00
24	2017285076354	09/15/17 - 09/25/17	10/16/17	0.00	0.00	0.00	0.00	0.00
24	2017293079026	10/05/17 - 10/13/17	10/30/17	0.00	0.00	0.00	0.00	0.00
24	2017326092398	10/27/17 - 11/07/17	11/27/17	0.00	0.00	0.00	0.00	0.00
24	2018025003817	01/05/18 - 01/17/18	01/29/18	0.00	0.00	0.00	0.00	0.00
24	5218032001225	08/15/17 - 08/25/17	03/12/18	0.00	0.00	0.00	0.00	0.00
24	2018036034901	01/12/18 - 01/28/18	02/12/18	0.00	0.00	0.00	0.00	0.00
24	2018058048446	01/27/18 - 02/09/18	03/05/18	0.00	0.00	0.00	0.00	0.00
24	2018127032176	04/10/18 - 04/18/18	05/14/18	0.00	0.00	0.00	0.00	0.00
24	2019052099189	06/22/18 - 06/27/18	02/25/19	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 CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,667.50	ADJUSTMENTS	0.00
COVERED CHARGES	96,071.50	CONTRACTUAL ALLOW	47,692.25
NON-COVERD CHARGES	596.00	TOTAL MEDICAID LIAB	48,379.25
		LESS: COB	48,379.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	9,414.00	596.00
ROUTINE NURSERY	3	0	6,146.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	15,560.00	596.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	4	0	19,368.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	19,368.00	0.00
TOTAL ACCOMODATIONS	16	0	34,928.00	596.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,819.50	0.00	OTHER LAB	707.00	0.00
MED/SURG SUPPLY	2,345.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,528.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,560.00	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	8,517.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,856.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,363.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,422.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,850.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,965.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,643.25	0.00	INJECTABLE DRUGS	9,816.75	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	134.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,613.75	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			

TOTAL ANCILLARY	61,143.50	0.00
TOTAL ACCOMODATIONS	34,928.00	596.00
TOTAL CHARGES	96,071.50	596.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,933,060.13	ADJUSTMENTS	52,399.68
COVERED CHARGES	15,086,190.00	CONTRACTUAL ALLOW	13,836,082.35
NON-COVERD CHARGES	2,846,870.13	TOTAL MEDICAID LIAB	1,250,107.65
		LESS: COB	1,561.53
		LESS: COPAYMENT	1,527.74
		REIMBURSEMENT	1,247,018.38
		ALL OTHER	1,107,990.32
		FEE SCHEDULE-LAB	132,035.52
		INJECTABLE DRUGS	6,992.54

TOTAL NUMBER OF CLAIMS 3,724

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,227.05	167,058.95	OTHER LAB	187,418.25	0.00
MED/SURG SUPPLY	411,389.75	739.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,270,571.75	177,155.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,820,145.00	699,790.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,874.50	FEE SCHEDULE LAB	3,085,804.00	233,122.00
EKG/ECG	341,722.50	465.75	MRI SERVICES	123,760.00	26,891.00
IV THERAPY	302,221.75	9,143.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	988,307.84	413,242.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,530.75	4,294.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,283.00	5,257.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	387,797.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	215,395.62	35,563.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,495,159.12	19,129.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	259,652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	10,360.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	155,250.89	214,110.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,925.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,520.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	34,242.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,429.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	9,652.50	IMPL DEV CHARGE PATIENTS	68,900.00	10,500.00
LITHOTRIPSY	18,400.50	0.00	NO CC/INVALID REV CODE	0.00	359.00
OTHER IMAGING SERVICE	339,708.25	193,001.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,753.75	9,419.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	41,266.25	30,116.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	197,073.50	517,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,967.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139,483.48	11,637.00			

TOTAL ANCILLARY	15,086,190.00	2,846,870.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,086,190.00	2,846,870.13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
905	2017261027673	07/26/17 - 07/26/17	09/25/17	0.00	359.00	0.00	0.00	0.00
TOTAL				0.00	359.00	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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	267,617.76	ADJUSTMENTS	0.00
COVERED CHARGES	210,339.75	CONTRACTUAL ALLOW	150,102.12
NON-COVERD CHARGES	57,278.01	TOTAL MEDICAID LIAB	60,237.63
		LESS: COB	60,213.63
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,418.25	2,857.75	OTHER LAB	3,973.25	0.00
MED/SURG SUPPLY	3,188.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,990.25	884.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,112.75	13,709.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,862.00	7,701.25
EKG/ECG	3,726.00	465.75	MRI SERVICES	0.00	6,722.75
IV THERAPY	4,213.00	798.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,164.25	2,736.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	962.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	879.75	2,858.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,272.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,511.00	6,501.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,154.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,818.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,557.50	4,241.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,466.50	7,801.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,069.50	0.00			

TOTAL ANCILLARY	210,339.75	57,278.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	210,339.75	57,278.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,392,124.45	ADJUSTMENTS	108.88
COVERED CHARGES	1,194,786.93	CONTRACTUAL ALLOW	1,165,750.07
NON-COVERD CHARGES	197,337.52	TOTAL MEDICAID LIAB	29,036.86
		LESS: COB	0.00
		LESS: COPAYMENT	1,059.00
		REIMBURSEMENT	27,977.86
		TOTAL NUMBER OF CLAIMS	520

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,940.65	10,766.68	OTHER LAB	5,080.00	0.00
MED/SURG SUPPLY	919.75	61.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,397.00	9,196.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,142.50	130,100.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	305,054.75	16,342.75
EKG/ECG	21,545.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,315.50	849.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	343.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,271.25	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	536,679.25	1,171.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,092.03	15,749.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	281.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,007.25	12,818.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,887.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,111.00	0.00			

TOTAL ANCILLARY	1,194,786.93	197,337.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,194,786.93	197,337.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,456.75	ADJUSTMENTS	0.00
COVERED CHARGES	17,656.75	CONTRACTUAL ALLOW	10,359.07
NON-COVERD CHARGES	3,800.00	TOTAL MEDICAID LIAB	7,297.68
		LESS: COB	7,282.68
		LESS: COPAYMENT	15.00
		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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	3,294.00	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	5,188.00	3,543.00
EKG/ECG	465.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,634.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.00	257.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,656.75	3,800.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,656.75	3,800.00

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

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,423,019.96	ADJUSTMENTS	0.00
COVERED CHARGES	2,280,072.58	CONTRACTUAL ALLOW	2,171,260.58
NON-COVERD CHARGES	142,947.38	TOTAL MEDICAID LIAB	108,812.00
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	108,734.00
		TOTAL NUMBER OF CLAIMS	20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,627.75	6,014.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	144,085.50	981.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,076.25	4,965.25	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	17,858.75	0.00
EKG/ECG	4,088.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,979.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,266,564.25	81,262.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,278.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,540.50	25.00	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	16,157.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	111,169.58	33,100.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	517,183.00	1,144.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,463.75	15,454.50			
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	0.00	0.00			

TOTAL ANCILLARY	2,280,072.58	142,947.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,280,072.58	142,947.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM MEDICAL CENTERS
350 HOSPITAL DR
MACON,GA 31217-3838

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,980,955.01	ADJUSTMENTS	132,190.94
COVERED CHARGES	23,804,686.99	CONTRACTUAL ALLOW	17,839,320.70
NON-COVERD CHARGES	1,176,268.02	TOTAL MEDICAID LIAB	5,965,366.29
		LESS: COB	37,397.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,927,969.04

TOTAL NUMBER OF ADMISSIONS 562

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,837	0	1,500,763.00	701,603.00
ROUTINE NURSERY	435	0	615,007.00	255,857.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,272	0	2,115,770.00	957,460.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	501	0	1,354,437.00	0.00
NICU	10	0	39,880.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	511	0	1,394,317.00	0.00
TOTAL ACCOMODATIONS	2,783	0	3,510,087.00	957,460.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,191,946.27	33,419.40	OTHER LAB	255,091.00	0.00
MED/SURG SUPPLY	562,628.72	470.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,476,743.00	47,168.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420,934.00	441.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,752,397.00	13,359.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	206,642.34	17,767.56	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	231,246.00	2,658.00	MRI SERVICES	300,750.00	0.00
IV THERAPY	614.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,938,815.00	17,813.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	355,171.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,199,241.00	21,726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,909.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,596.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,501,065.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	442,634.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	114,625.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	5,874.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	79,881.62	12,246.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,927.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	205,598.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,299.00	10,006.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,288,750.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	202,369.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	153,350.00	16,720.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,215.00	25,014.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	547,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,778.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	213,946.75	0.00			

TOTAL ANCILLARY	20,294,599.99	218,808.02
TOTAL ACCOMODATIONS	3,510,087.00	957,460.00
TOTAL CHARGES	23,804,686.99	1,176,268.02

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	258,034.37	ADJUSTMENTS	0.00
COVERED CHARGES	232,123.37	CONTRACTUAL ALLOW	135,022.46
NON-COVERD CHARGES	25,911.00	TOTAL MEDICAID LIAB	97,100.91
		LESS: COB	97,100.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	16	0	13,904.00	8,832.00
ROUTINE NURSERY	22	0	36,046.00	16,322.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	38	0	49,950.00	25,154.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	7,701.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	7,701.00	0.00
TOTAL ACCOMODATIONS	41	0	57,651.00	25,154.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,292.73	0.00	OTHER LAB	6,805.00	0.00
MED/SURG SUPPLY	2,363.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,036.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,914.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,909.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	886.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,578.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,470.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,208.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,510.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,903.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,410.00	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	442.00	757.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,454.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,471.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,742.60	0.00			

TOTAL ANCILLARY	174,472.37	757.00
TOTAL ACCOMODATIONS	57,651.00	25,154.00
TOTAL CHARGES	232,123.37	25,911.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,276,429.38	ADJUSTMENTS	429,187.26
COVERED CHARGES	19,168,574.02	CONTRACTUAL ALLOW	17,034,060.88
NON-COVERD CHARGES	4,107,855.36	TOTAL MEDICAID LIAB	2,134,513.14
		LESS: COB	63,989.50
		LESS: COPAYMENT	5,491.68
		REIMBURSEMENT	2,065,031.96
		ALL OTHER	1,787,258.79
		FEE SCHEDULE-LAB	155,984.82
		INJECTABLE DRUGS	121,788.35

TOTAL NUMBER OF CLAIMS 4,459

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,126.72	171.60	OTHER LAB	271,654.00	0.00
MED/SURG SUPPLY	360,276.16	59,475.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	701,305.00	122,268.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,703,778.00	617,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,051.00	41,650.61	FEE SCHEDULE LAB	2,496,895.00	174,692.00
EKG/ECG	340,667.00	9,746.00	MRI SERVICES	380,708.00	54,898.00
IV THERAPY	178,490.00	724.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	997,173.00	467,116.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,953.00	1,713.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118,320.00	62,629.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	231,749.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	271,968.00	96,102.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,632,072.00	252,723.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	368,685.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	841,108.46	620,137.09
RADIOLOGY THERAPEUTIC	690,140.00	696,705.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	475.00	7,500.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,800.00	7,536.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	36,282.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63,286.00	55,286.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,521.67	104,999.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	549,972.00	199,609.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,706.00	18,810.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	186,612.00	257,818.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	449,291.00	127,839.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	336,728.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	403,063.01	13,637.25			

TOTAL ANCILLARY	19,168,574.02	4,107,855.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,168,574.02	4,107,855.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	365,522.23	ADJUSTMENTS	0.00
COVERED CHARGES	229,125.16	CONTRACTUAL ALLOW	137,040.78
NON-COVERD CHARGES	136,397.07	TOTAL MEDICAID LIAB	92,084.38
		LESS: COB	92,042.38
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,622.10	0.00	OTHER LAB	4,392.00	0.00
MED/SURG SUPPLY	900.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,876.00	1,088.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,874.00	85,717.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	683.02	FEE SCHEDULE LAB	43,317.00	1,320.00
EKG/ECG	4,873.00	0.00	MRI SERVICES	5,708.00	14,066.00
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	3,608.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	349.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,647.00	1,980.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,483.61	12,622.03
RADIOLOGY THERAPEUTIC	1,607.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	935.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	611.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	720.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,924.00	12,555.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,782.00	629.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,360.00	3,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,376.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,426.45	0.00			

TOTAL ANCILLARY	229,125.16	136,397.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	229,125.16	136,397.07

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	380,701.06	ADJUSTMENTS	379.58
COVERED CHARGES	338,487.20	CONTRACTUAL ALLOW	329,533.96
NON-COVERD CHARGES	42,213.86	TOTAL MEDICAID LIAB	8,953.24
		LESS: COB	786.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	7,924.24
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,442.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,003.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,131.00	2,943.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,295.00	28,591.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58,008.00	2,475.00
EKG/ECG	4,430.00	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	208,989.00	2,962.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,689.89	593.86
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,499.00	4,649.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	338,487.20	42,213.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338,487.20	42,213.86

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,413.57	ADJUSTMENTS	0.00
COVERED CHARGES	55,041.57	CONTRACTUAL ALLOW	49,147.04
NON-COVERD CHARGES	19,372.00	TOTAL MEDICAID LIAB	5,894.53
		LESS: COB	5,879.53
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	617.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,680.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,043.00	15,820.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,574.00	314.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,669.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,513.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,124.00	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,984.00	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	1,719.76	502.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,179.00	0.00			

TOTAL ANCILLARY	55,041.57	19,372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,041.57	19,372.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL INC
745 POPLAR ROAD
NEWNAN,GA 30265-1618

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,536,696.58	ADJUSTMENTS	12,276.88
COVERED CHARGES	1,446,250.08	CONTRACTUAL ALLOW	1,292,226.58
NON-COVERD CHARGES	90,446.50	TOTAL MEDICAID LIAB	154,023.50
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	153,759.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,266.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	614.00	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	2,666.00	465.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,155.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	990.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,290,074.95	88,605.50
RADIOLOGY THERAPEUTIC	32,720.00	1,376.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	72,764.00	0.00			

TOTAL ANCILLARY	1,446,250.08	90,446.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,446,250.08	90,446.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	111,788,803.21	ADJUSTMENTS	4,907,100.95
COVERED CHARGES	100,876,876.11	CONTRACTUAL ALLOW	69,987,064.07
NON-COVERD CHARGES	10,911,927.10	TOTAL MEDICAID LIAB	30,889,812.04
		LESS: COB	485,202.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,404,609.66

TOTAL NUMBER OF ADMISSIONS 2,262

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	11,715	0	16,428,195.00	1,990,504.00
ROUTINE NURSERY	1,647	0	2,579,708.00	389,281.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13,362	0	19,007,903.00	2,379,785.00
SPECIAL CARE SERVICES				
CCU	288	0	1,747,645.00	24,572.00
ICU	1,813	0	9,881,834.00	1,296,173.00
NICU	207	0	750,780.00	260,640.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,308	0	12,380,259.00	1,581,385.00
TOTAL ACCOMODATIONS	15,670	0	31,388,162.00	3,961,170.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,928,170.49	406,669.40	OTHER LAB	482,375.00	5,616.00
MED/SURG SUPPLY	4,201,344.25	212,023.11	RECREATIONAL THERAPY	2,641.00	0.00
LABORATORY-GENERAL	14,236,939.00	574,343.12	EDUCATION & TRAINING	590.00	0.00
RADIOLOGY-DIAGNOSTIC	1,224,080.78	52,330.04	OTHER THERAPEUTIC SVC	0.00	304,716.50
CT SCAN	2,949,398.00	40,398.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,069,870.50	34,228.03	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	492,399.00	5,775.00	MRI SERVICES	1,132,296.00	17,916.00
IV THERAPY	2,063.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,023,777.00	102,733.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,003,098.00	7,201.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,351,468.08	408,351.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,041,412.00	10,780.00	AMBULANCE	0.00	0.00
GI SERVICES	568,012.00	10,429.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,582,924.00	5,085.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	971,396.00	7,076.00	DRUG-SPECIFIC/HOME IV	0.00	95,114.32
LABORATORY PATHOLOGIC	670,149.00	13,946.00	INJECTABLE DRUGS	9,088,917.31	3,117,331.05
RADIOLOGY THERAPEUTIC	175,072.00	6,768.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	458,200.24	20,615.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	201,339.47	7,576.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,381,445.00	164,137.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,586.00	335.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,153,493.74	9,296.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	222,240.00
OTHER IMAGING SERVICE	347,569.00	442,308.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,342,335.25	431,863.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,351.00	146,727.00			
AUDIOLOGY	15,182.00	0.00			
CARDIOLOGY	2,832,985.00	64,985.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	333,910.00	1,628.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	88,925.00	216.00			

TOTAL ANCILLARY	69,488,714.11	6,950,757.10
TOTAL ACCOMODATIONS	31,388,162.00	3,961,170.00
TOTAL CHARGES	100,876,876.11	10,911,927.10

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 09/01/17 THROUGH 08/31/18
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	2017278046530	09/27/17 - 09/29/17	10/09/17	0.00	8,958.00	0.00	0.00	0.00
615	2017285072718	09/25/17 - 09/30/17	10/16/17	0.00	8,958.00	0.00	0.00	0.00
615	2017297049425	10/09/17 - 10/15/17	10/30/17	0.00	8,958.00	0.00	0.00	0.00
615	2017300066139	09/25/17 - 10/05/17	11/06/17	0.00	2,698.00	0.00	0.00	0.00
615	2017304062699	10/03/17 - 10/24/17	11/06/17	0.00	2,698.00	0.00	0.00	0.00
615	2017310036245	10/20/17 - 10/31/17	11/13/17	0.00	5,396.00	0.00	0.00	0.00
615	2017346066915	12/05/17 - 12/06/17	12/18/17	0.00	8,958.00	0.00	0.00	0.00
614	2318025000051	12/13/17 - 12/20/17	02/12/18	0.00	2,698.00	0.00	1,393.41	0.00
615	2018046070861	02/06/18 - 02/10/18	02/19/18	0.00	8,958.00	0.00	0.00	0.00
615	2018050024364	01/13/18 - 01/30/18	02/26/18	0.00	8,958.00	0.00	0.00	0.00
615	2018050024905	02/04/18 - 02/14/18	02/26/18	0.00	8,958.00	0.00	0.00	0.00
615	2018053091279	01/14/18 - 02/05/18	03/05/18	0.00	8,958.00	0.00	0.00	0.00
615	2018061090869	02/04/18 - 02/25/18	03/12/18	0.00	8,958.00	0.00	0.00	0.00
615	2018086070185	03/14/18 - 03/22/18	04/02/18	0.00	2,698.00	0.00	0.00	0.00
615	2018103070422	04/05/18 - 04/07/18	04/23/18	0.00	8,958.00	0.00	0.00	0.00
614	2318127000032	01/27/18 - 02/12/18	05/21/18	0.00	2,698.00	0.00	5,562.03	0.00
615	5918130001930	12/10/17 - 03/23/18	05/14/18	0.00	7,177.00	0.00	0.00	0.00
615	2218169000539	01/03/18 - 02/09/18	06/25/18	0.00	5,396.00	0.00	0.00	0.00
615	2018173066831	06/13/18 - 06/17/18	07/02/18	0.00	2,698.00	0.00	0.00	0.00
615	2218184005912	04/24/18 - 04/30/18	07/09/18	0.00	2,698.00	0.00	0.00	0.00
615	2018225039970	07/30/18 - 08/08/18	08/20/18	0.00	4,479.00	0.00	0.00	0.00
614	2318239000239	06/27/18 - 07/02/18	09/10/18	0.00	3,221.00	0.00	1,182.52	0.00
615	2018240090543	08/17/18 - 08/23/18	09/10/18	0.00	8,958.00	0.00	0.00	0.00
614	2318242000227	06/20/18 - 07/10/18	09/17/18	0.00	4,479.00	0.00	3,583.73	0.00
615	2018244032506	08/22/18 - 08/25/18	09/10/18	0.00	8,958.00	0.00	0.00	0.00
615	2018249100813	08/18/18 - 08/31/18	09/10/18	0.00	4,479.00	0.00	0.00	0.00
614	2018262075325	05/01/18 - 05/09/18	09/24/18	0.00	3,221.00	0.00	0.00	0.00
615	2018269051121	08/16/18 - 09/08/18	10/01/18	0.00	8,958.00	0.00	0.00	0.00
614	2018282096412	06/06/18 - 06/22/18	10/15/18	0.00	2,698.00	0.00	0.00	0.00
614	5218297000135	06/05/18 - 09/01/18	10/29/18	0.00	8,958.00	0.00	0.00	0.00
615	5218309000369	06/07/18 - 07/22/18	11/12/18	0.00	2,698.00	0.00	0.00	0.00
615	2019108076167	06/14/18 - 06/20/18	04/22/19	0.00	8,958.00	0.00	0.00	0.00
614	5219108001721	02/27/18 - 04/11/18	04/22/19	0.00	2,698.00	0.00	0.00	0.00
615	2019136087038	07/15/18 - 07/17/18	05/20/19	0.00	8,958.00	0.00	0.00	0.00
615	2219141011903	02/16/18 - 03/23/18	05/27/19	0.00	2,698.00	0.00	0.00	0.00
615	2019150134464	08/06/18 - 01/02/19	06/03/19	0.00	2,428.00	0.00	0.00	0.00
614	2219234014188	07/27/18 - 09/13/18	08/26/19	0.00	8,958.00	0.00	0.00	0.00
TOTAL				0.00	222,240.00	0.00	11,721.69	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	628,533.25	ADJUSTMENTS	0.00
COVERED CHARGES	611,853.25	CONTRACTUAL ALLOW	248,783.70
NON-COVERD CHARGES	16,680.00	TOTAL MEDICAID LIAB	363,069.55
		LESS: COB	363,069.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	99	0	142,670.00	12,760.00
ROUTINE NURSERY	7	0	8,400.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	106	0	151,070.00	12,760.00
SPECIAL CARE SERVICES				
CCU	3	0	18,429.00	0.00
ICU	4	0	24,572.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	43,001.00	0.00
TOTAL ACCOMODATIONS	113	0	194,071.00	12,760.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,606.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,722.12	194.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,880.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,177.40	0.00	OTHER THERAPEUTIC SVC	0.00	2,641.00
CT SCAN	15,097.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,064.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,926.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,833.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	90,774.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,841.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,599.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,683.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,565.00	0.00	INJECTABLE DRUGS	62,941.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,480.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,524.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,940.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	134.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,320.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	777.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,206.31	851.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,514.00	234.00			
AUDIOLOGY	278.00	0.00			
CARDIOLOGY	29,660.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	417,782.25	3,920.00
TOTAL ACCOMODATIONS	194,071.00	12,760.00
TOTAL CHARGES	611,853.25	16,680.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,474,750.17	ADJUSTMENTS	895,092.55
COVERED CHARGES	29,250,685.93	CONTRACTUAL ALLOW	22,747,504.56
NON-COVERD CHARGES	11,224,064.24	TOTAL MEDICAID LIAB	6,503,181.37
		LESS: COB	7,626.98
		LESS: COPAYMENT	19,727.79
		REIMBURSEMENT	6,475,826.60
		ALL OTHER	4,269,056.89
		FEE SCHEDULE-LAB	627,195.49
		INJECTABLE DRUGS	1,579,574.22

TOTAL NUMBER OF CLAIMS 11,056

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	532,905.99	519,352.44	OTHER LAB	334,958.00	3,744.00
MED/SURG SUPPLY	771,323.72	40,618.00	RECREATIONAL THERAPY	5,282.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	885,624.84	77,371.16	OTHER THERAPEUTIC SVC	230.00	191,762.00
CT SCAN	2,338,825.00	1,124,219.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,953.00	42,224.10	FEE SCHEDULE LAB	6,963,437.00	885,261.00
EKG/ECG	408,023.00	11,319.00	MRI SERVICES	976,179.00	539,752.00
IV THERAPY	1,252,863.00	25,131.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,234,417.50	1,089,587.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,554.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	275,088.00	48,575.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	568,866.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,875.00	187,237.00	CAST ROOM	903.00	0.00
EMERGENCY ROOM	4,241,253.00	101,312.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	617,092.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,590,809.61	3,049,297.64
RADIOLOGY THERAPEUTIC	406,267.00	325,274.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	19,169.12	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	690.00	14,523.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	282,962.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,318.00	12,216.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,094.27	524,240.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	97,674.00
OTHER IMAGING SERVICE	707,686.00	931,180.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	611,172.00	156,441.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	520,201.00	372,034.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	820,583.00	351,460.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,369.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	909,843.00	200,128.00			

TOTAL ANCILLARY	29,250,685.93	11,224,064.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,250,685.93	11,224,064.24

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 09/01/17 THROUGH 08/31/18
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	2017283093673	10/04/17 - 10/04/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017342062087	09/05/17 - 09/05/17	12/18/17	0.00	4,479.00	0.00	0.00	0.00
615	2017342062087	09/05/17 - 09/05/17	12/18/17	0.00	4,479.00	0.00	0.00	0.00
615	2017352023586	12/12/17 - 12/12/17	12/25/17	0.00	4,479.00	0.00	0.00	0.00
615	2017352023586	12/12/17 - 12/12/17	12/25/17	0.00	4,479.00	0.00	0.00	0.00
615	2018008022629	01/02/18 - 01/02/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018010063309	01/05/18 - 01/05/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018010063309	01/05/18 - 01/05/18	01/15/18	0.00	4,479.00	0.00	0.00	0.00
615	2018018073249	01/10/18 - 01/10/18	01/22/18	0.00	4,479.00	0.00	0.00	0.00
615	2018025097127	01/03/18 - 01/03/18	01/29/18	0.00	4,479.00	0.00	0.00	0.00
615	2018025097127	01/03/18 - 01/03/18	01/29/18	0.00	4,479.00	0.00	0.00	0.00
615	2018058045666	02/21/18 - 02/21/18	03/05/18	0.00	2,698.00	0.00	0.00	0.00
615	2018058045666	02/21/18 - 02/21/18	03/05/18	0.00	4,479.00	0.00	0.00	0.00
615	2218093009288	03/07/18 - 03/07/18	04/09/18	0.00	4,479.00	0.00	0.00	0.00
615	2218093009288	03/07/18 - 03/07/18	04/09/18	0.00	4,479.00	0.00	0.00	0.00
615	5918163000425	05/22/18 - 05/22/18	06/18/18	0.00	4,479.00	0.00	0.00	0.00
615	2018178078549	06/12/18 - 06/12/18	07/02/18	0.00	4,479.00	0.00	0.00	0.00
615	2018178078549	06/12/18 - 06/12/18	07/02/18	0.00	4,479.00	0.00	0.00	0.00
615	2018193073618	04/16/18 - 04/16/18	07/16/18	0.00	4,479.00	0.00	0.00	0.00
615	2018193073618	04/16/18 - 04/16/18	07/16/18	0.00	4,479.00	0.00	0.00	0.00
615	2218247005031	05/25/18 - 05/25/18	09/10/18	0.00	2,698.00	0.00	0.00	0.00
615	5919064000148	08/06/18 - 08/06/18	03/11/19	0.00	4,479.00	0.00	0.00	0.00
615	5919064000148	08/06/18 - 08/06/18	03/11/19	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	97,674.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,030,110.99	ADJUSTMENTS	0.00
COVERED CHARGES	427,978.33	CONTRACTUAL ALLOW	-24,949.35
NON-COVERD CHARGES	602,132.66	TOTAL MEDICAID LIAB	452,927.68
		LESS: COB	452,469.09
		LESS: COPAYMENT	458.59
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 197

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,814.33	18,233.07	OTHER LAB	6,552.00	86.00
MED/SURG SUPPLY	19,869.48	57.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,246.00	6,121.08	OTHER THERAPEUTIC SVC	0.00	5,282.00
CT SCAN	7,870.00	51,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	108,555.00	10,690.00
EKG/ECG	1,540.00	308.00	MRI SERVICES	0.00	17,916.00
IV THERAPY	40,551.00	2,434.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,997.00	107,021.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,454.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,716.00	136.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,860.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,021.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,839.00	2,059.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,918.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	14,114.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,704.52	252,789.11
RADIOLOGY THERAPEUTIC	6,425.00	360.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	90.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	672.00	56,397.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,043.00	28,374.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,449.00	1,731.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	7,555.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,129.00	4,287.00			
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	16,774.00	9,571.00			

TOTAL ANCILLARY	427,978.33	602,132.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	427,978.33	602,132.66

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	268,740.21	ADJUSTMENTS	2,960.60
COVERED CHARGES	243,872.35	CONTRACTUAL ALLOW	229,607.56
NON-COVERD CHARGES	24,867.86	TOTAL MEDICAID LIAB	14,264.79
		LESS: COB	0.00
		LESS: COPAYMENT	630.00
		REIMBURSEMENT	13,634.79

TOTAL NUMBER OF CLAIMS 246

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,194.40	1,202.80	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	2,041.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,440.00	6,292.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,027.00	3,028.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,515.00	2,617.00
EKG/ECG	6,006.00	154.00	MRI SERVICES	2,698.00	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	4,492.00	336.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,665.00	572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,668.95	359.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	90.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,112.00	7,174.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,250.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	591.00	793.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	486.00	0.00			

TOTAL ANCILLARY	243,872.35	24,867.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	243,872.35	24,867.86

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,242.08	ADJUSTMENTS	0.00
COVERED CHARGES	10,004.08	CONTRACTUAL ALLOW	4,038.67
NON-COVERD CHARGES	238.00	TOTAL MEDICAID LIAB	5,965.41
		LESS: COB	5,953.41
		LESS: COPAYMENT	12.00
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	668.00	186.00	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	2,760.00	52.00
EKG/ECG	154.00	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	4,745.00	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	52.08	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,004.08	238.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,004.08	238.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,074,200.87	ADJUSTMENTS	165,751.62
COVERED CHARGES	5,434,211.98	CONTRACTUAL ALLOW	3,910,194.94
NON-COVERD CHARGES	639,988.89	TOTAL MEDICAID LIAB	1,524,017.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,954.59
		REIMBURSEMENT	1,522,062.45

TOTAL NUMBER OF CLAIMS 248

GEORGIA 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,837.63	1,775.83	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72,859.78	4,866.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,055.08	11,837.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,102.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,224.00	FEE SCHEDULE LAB	350,736.00	28,055.00
EKG/ECG	924.00	154.00	MRI SERVICES	0.00	3,221.00
IV THERAPY	470,343.00	11,550.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	523,765.00	29,052.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	402.00	136.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,698.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	531.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,275,777.49	438,298.98
RADIOLOGY THERAPEUTIC	134,478.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,981.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,967.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	513.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	108,246.00	78,798.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	103.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,067.00	11,382.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,325.00	94.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,880.00	2,200.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205,018.00	6,884.00			

TOTAL ANCILLARY	5,434,211.98	639,988.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,434,211.98	639,988.89

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,677.40	ADJUSTMENTS	0.00
COVERED CHARGES	57,502.56	CONTRACTUAL ALLOW	24,132.32
NON-COVERD CHARGES	174.84	TOTAL MEDICAID LIAB	33,370.24
		LESS: COB	33,352.24
		LESS: COPAYMENT	18.00
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	395.88	174.84	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54.00	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	930.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,834.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	46,992.68	0.00
RADIOLOGY THERAPEUTIC	3,296.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	57,502.56	174.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	57,502.56	174.84

** 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,476,564.17	ADJUSTMENTS	26,066.54
COVERED CHARGES	5,395,259.65	CONTRACTUAL ALLOW	3,234,194.35
NON-COVERD CHARGES	81,304.52	TOTAL MEDICAID LIAB	2,161,065.30
		LESS: COB	14,652.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,146,412.68

TOTAL NUMBER OF ADMISSIONS 262

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	717	0	533,126.00	15,740.00
ROUTINE NURSERY	40	0	30,000.00	12,315.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	42.50
TOTAL ROUTINE	757	0	563,126.00	28,097.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	376	0	592,250.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	376	0	592,250.00	0.00
TOTAL ACCOMODATIONS	1,133	0	1,155,376.00	28,097.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356,335.10	0.00	OTHER LAB	26,281.00	0.00
MED/SURG SUPPLY	325,794.49	59.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	989,087.55	0.00	EDUCATION & TRAINING	4,720.00	0.00
RADIOLOGY-DIAGNOSTIC	85,957.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	367,281.00	2,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,989.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,032.00	0.00	MRI SERVICES	82,693.00	0.00
IV THERAPY	90,954.57	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290,462.78	158.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,938.04	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	430,137.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,695.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,283.97	0.00	SPECIAL SERVICES	0.00	6,475.00
RECOVERY ROOM	26,004.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,624.71	0.00	INJECTABLE DRUGS	384,252.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,712.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	28,243.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	61,250.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,348.00	2,360.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,243.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,318.00
OTHER IMAGING SERVICE	23,590.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,210.50	27,197.82			
ONCOLOGY	170.00	0.00			
NUCLEAR MEDICINE	5,411.00	768.00			
AUDIOLOGY	4,535.49	0.00			
CARDIOLOGY	101,888.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	757.10	0.00			

TOTAL ANCILLARY	4,239,883.65	53,207.02
TOTAL ACCOMODATIONS	1,155,376.00	28,097.50
TOTAL CHARGES	5,395,259.65	81,304.52

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 07/01/17 THROUGH 06/30/18
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	2017262041214	08/24/17 - 09/05/17	09/25/17	0.00	3,379.00	0.00	0.00	0.00
614	2018072067813	01/21/18 - 02/02/18	03/19/18	0.00	3,379.00	0.00	0.00	0.00
614	2018095072622	02/28/18 - 03/03/18	04/09/18	0.00	3,280.00	0.00	0.00	0.00
614	2018134026104	12/15/17 - 12/20/17	05/21/18	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	13,318.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,085.75	ADJUSTMENTS	0.00
COVERED CHARGES	4,085.75	CONTRACTUAL ALLOW	1,235.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,849.80
		LESS: COB	2,849.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	478.00	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	478.00	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	478.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL
902 N 7TH ST
CORDELE,GA 31015-3234

PROVIDER NUMBER
000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	294.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	963.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	192.00	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	271.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	651.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	869.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,607.75	0.00
TOTAL ACCOMODATIONS	478.00	0.00
TOTAL CHARGES	4,085.75	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,238,926.89	ADJUSTMENTS	276,646.68
COVERED CHARGES	5,419,669.63	CONTRACTUAL ALLOW	4,341,563.93
NON-COVERD CHARGES	819,257.26	TOTAL MEDICAID LIAB	1,078,105.70
		LESS: COB	494.26
		LESS: COPAYMENT	4,082.62
		REIMBURSEMENT	1,073,528.82
		ALL OTHER	796,237.50
		FEE SCHEDULE-LAB	150,095.03
		INJECTABLE DRUGS	127,196.29

TOTAL NUMBER OF CLAIMS 3,793

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,705.93	29,342.45	OTHER LAB	150,610.23	2,116.00
MED/SURG SUPPLY	144,684.37	11,811.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	161.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	232,031.37	26,367.19	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	877,392.00	154,645.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,262.00	5,388.00	FEE SCHEDULE LAB	1,447,398.13	81,059.92
EKG/ECG	60,914.00	426.00	MRI SERVICES	161,449.00	23,417.00
IV THERAPY	198,167.87	45,056.68	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	415,593.28	88,622.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,558.78	182.77	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,529.39	5,912.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,989.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	690,807.67	15,178.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,742.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391,918.77	237,110.19
RADIOLOGY THERAPEUTIC	15,273.38	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	611.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	367.00	2,124.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,750.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84,650.95	12,455.54	TRAUMA RESPONSE	0.00	1,133.87
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,421.75	13,501.95
LITHOTRIPSY	23,290.68	0.00	NO CC/INVALID REV CODE	0.00	6,921.00
OTHER IMAGING SERVICE	121,519.00	14,451.00			
BLOOD	0.00	2,222.05			
BLOOD STORAGE & PRO.	4,371.23	3,226.86			
ONCOLOGY	7,846.00	2,722.00			
NUCLEAR MEDICINE	71,819.85	19,924.00			
AUDIOLOGY	238.71	0.00			
CARDIOLOGY	51,132.00	8,574.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,018.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,967.29	841.41			

TOTAL ANCILLARY	5,419,669.63	819,257.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,419,669.63	819,257.26

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 07/01/17 THROUGH 06/30/18
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
525	5917262001649	07/06/17 - 07/06/17	09/25/17	0.00	262.00	0.00	0.00	0.00
614	2018025067193	12/28/17 - 12/28/17	01/29/18	0.00	3,280.00	0.00	0.00	0.00
614	2018096018899	03/09/18 - 03/09/18	04/09/18	0.00	3,379.00	0.00	0.00	0.00
TOTAL				0.00	6,921.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	110,324.92	ADJUSTMENTS	0.00
COVERED CHARGES	59,587.23	CONTRACTUAL ALLOW	13,778.76
NON-COVERD CHARGES	50,737.69	TOTAL MEDICAID LIAB	45,808.47
		LESS: COB	45,787.16
		LESS: COPAYMENT	21.31
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.04	920.23	OTHER LAB	2,987.00	0.00
MED/SURG SUPPLY	1,747.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,310.00	228.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,326.00	4,413.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,196.32	2,674.00
EKG/ECG	852.00	0.00	MRI SERVICES	2,394.00	3,379.00
IV THERAPY	1,021.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,991.88	4,991.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302.06	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,427.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	599.15	29,034.58
RADIOLOGY THERAPEUTIC	726.68	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	3,280.00
OTHER IMAGING SERVICE	4,520.00	1,697.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	820.00	120.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	700.95	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	59,587.23	50,737.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	59,587.23	50,737.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
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	2018078020972	02/21/18 - 02/21/18	03/26/18	0.00	3,280.00	0.00	0.00	0.00
TOTAL				0.00	3,280.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,408.96	ADJUSTMENTS	482.46
COVERED CHARGES	227,459.18	CONTRACTUAL ALLOW	215,320.20
NON-COVERD CHARGES	24,949.78	TOTAL MEDICAID LIAB	12,138.98
		LESS: COB	0.00
		LESS: COPAYMENT	438.00
		REIMBURSEMENT	11,700.98
		TOTAL NUMBER OF CLAIMS	217

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,306.51	627.80	OTHER LAB	616.00	0.00
MED/SURG SUPPLY	3,856.84	134.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,366.00	2,698.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,926.00	14,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,506.98	4,773.00
EKG/ECG	4,828.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,516.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,570.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	868.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	542.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,213.23	515.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	599.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,107.53	659.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.00	70.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	135.70	57.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,282.00	285.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	888.82	921.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,228.07	0.00			

TOTAL ANCILLARY	227,459.18	24,949.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	227,459.18	24,949.78

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	309.00	ADJUSTMENTS	0.00
COVERED CHARGES	150.00	CONTRACTUAL ALLOW	25.38
NON-COVERD CHARGES	159.00	TOTAL MEDICAID LIAB	124.62
		LESS: COB	124.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	159.00	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	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	150.00	159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	150.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	461,283.46	ADJUSTMENTS	17,245.47
COVERED CHARGES	390,870.97	CONTRACTUAL ALLOW	287,290.15
NON-COVERD CHARGES	70,412.49	TOTAL MEDICAID LIAB	103,580.82
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	103,454.82
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,355.37	531.97	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,802.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,376.00	2,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,043.00	666.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,075.73	1,250.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	336,253.53	65,223.52
RADIOLOGY THERAPEUTIC	18,980.84	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	984.00	553.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	390,870.97	70,412.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	390,870.97	70,412.49

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,629,397.41	ADJUSTMENTS	141,673.03
COVERED CHARGES	2,107,505.00	CONTRACTUAL ALLOW	1,477,902.87
NON-COVERD CHARGES	521,892.41	TOTAL MEDICAID LIAB	629,602.13
		LESS: COB	10,519.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	619,082.20

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	372	0	391,716.00	499,555.83
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	372	0	391,716.00	499,555.83
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	111	0	306,316.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	306,316.80	0.00
TOTAL ACCOMODATIONS	483	0	698,032.80	499,555.83

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,734.20	0.00	OTHER LAB	1,662.50	0.00
MED/SURG SUPPLY	186,989.74	1,839.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	139,263.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,839.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,327.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,581.63	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,836.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,453.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	578,445.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,396.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,507.00	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	1,184.00	0.00	INJECTABLE DRUGS	135,646.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,433.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,252.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,450.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	197.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,676.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,090.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,300.00	19,047.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,692.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,561.58	0.00			

TOTAL ANCILLARY	1,409,472.20	22,336.58
TOTAL ACCOMODATIONS	698,032.80	499,555.83
TOTAL CHARGES	2,107,505.00	521,892.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES HOSPITAL ,INC
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR,GA 30033-5918

PROVIDER NUMBER
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,290,572.86	ADJUSTMENTS	895,528.53
COVERED CHARGES	52,528,630.07	CONTRACTUAL ALLOW	35,689,691.24
NON-COVERD CHARGES	3,761,942.79	TOTAL MEDICAID LIAB	16,838,938.83
		LESS: COB	247,422.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,591,516.51

TOTAL NUMBER OF ADMISSIONS 2,132

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,184	0	7,187,116.65	2,020,796.54
ROUTINE NURSERY	1,657	0	2,703,703.00	693,804.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,841	0	9,890,819.65	2,714,600.54
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,465	0	3,981,384.49	0.00
NICU	24	0	84,000.00	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	1,489	0	4,065,384.49	0.00
TOTAL ACCOMODATIONS	10,330	0	13,956,204.14	2,714,600.54

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,510,658.95	5,246.60	OTHER LAB	422,319.00	0.00
MED/SURG SUPPLY	1,077,470.45	1,256.82	RECREATIONAL THERAPY	43,488.75	0.00
LABORATORY-GENERAL	5,711,390.93	3,904.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	947,397.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,683,298.00	127,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,062,079.27	402.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	517,760.68	0.00	MRI SERVICES	383,265.00	0.00
IV THERAPY	930,573.90	4,831.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,726,596.92	4,054.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	435,344.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,688,641.85	4,323.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	613,556.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	173,796.00	3,272.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,104,907.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,453,516.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	400.90
LABORATORY PATHOLOGIC	260,626.85	0.00	INJECTABLE DRUGS	4,227,800.16	53,250.80
RADIOLOGY THERAPEUTIC	250,139.39	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	820,530.24	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	414,997.34	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	151,636.00	237,896.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	55,295.07	2,395.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	701,704.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,124.00
OTHER IMAGING SERVICE	398,451.14	4,862.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	425,802.12	549,212.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	344,054.69	30,555.00			
AUDIOLOGY	120,831.92	0.00			
CARDIOLOGY	1,051,088.12	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	118,663.31	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	744,743.93	720.00			

TOTAL ANCILLARY	38,572,425.93	1,047,342.25
TOTAL ACCOMODATIONS	13,956,204.14	2,714,600.54
TOTAL CHARGES	52,528,630.07	3,761,942.79

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 07/01/17 THROUGH 06/30/18
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	2017219025318	07/30/17 - 08/02/17	08/14/17	0.00	193.00	0.00	0.00	0.00
948	2017248096992	08/30/17 - 09/01/17	09/11/17	0.00	193.00	0.00	0.00	0.00
948	2017264096644	09/13/17 - 09/16/17	09/25/17	0.00	193.00	0.00	0.00	0.00
948	2017272070746	09/12/17 - 09/15/17	10/09/17	0.00	386.00	0.00	0.00	0.00
948	2017283093964	10/04/17 - 10/06/17	10/16/17	0.00	193.00	0.00	0.00	0.00
948	2017320085086	11/04/17 - 11/10/17	11/20/17	0.00	193.00	0.00	0.00	0.00
-1	2017321069135	11/09/17 - 11/11/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017324040474	11/13/17 - 11/15/17	11/27/17	0.00	193.00	0.00	0.00	0.00
948	2217326012271	10/15/17 - 10/24/17	11/27/17	0.00	193.00	0.00	0.00	0.00
948	2017331030055	11/14/17 - 11/17/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017332079514	11/08/17 - 11/09/17	12/04/17	0.00	193.00	0.00	0.00	0.00
948	2017334079414	11/19/17 - 11/23/17	12/04/17	0.00	386.00	0.00	0.00	0.00
948	2217362005201	10/30/17 - 10/31/17	01/01/18	0.00	193.00	0.00	0.00	0.00
948	2018003063766	12/26/17 - 12/27/17	01/08/18	0.00	193.00	0.00	0.00	0.00
948	2018008024554	01/01/18 - 01/03/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018008024644	12/27/17 - 01/04/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018009067157	01/03/18 - 01/05/18	01/15/18	0.00	386.00	0.00	0.00	0.00
948	2018009067186	12/22/17 - 12/31/17	01/15/18	0.00	193.00	0.00	0.00	0.00
948	2018009068273	01/03/18 - 01/05/18	01/15/18	0.00	193.00	0.00	0.00	0.00
948	2018022031038	11/27/17 - 11/29/17	01/29/18	0.00	193.00	0.00	0.00	0.00
948	2018026074691	01/18/18 - 01/22/18	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2218032003588	01/07/18 - 01/10/18	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2018032097159	11/02/17 - 11/04/17	02/05/18	0.00	193.00	0.00	0.00	0.00
948	2018040074619	02/03/18 - 02/06/18	02/19/18	0.00	193.00	0.00	0.00	0.00
-1	2318043000242	12/08/17 - 12/19/17	02/26/18	0.00	193.00	0.00	2,091.17	0.00
948	2218064002233	02/20/18 - 02/26/18	03/12/18	0.00	193.00	0.00	0.00	0.00
948	2018066085157	02/27/18 - 03/02/18	03/12/18	0.00	193.00	0.00	0.00	0.00
-1	2318072000127	11/18/17 - 11/20/17	03/26/18	0.00	193.00	0.00	877.82	0.00
948	2018072085528	03/05/18 - 03/09/18	03/19/18	0.00	193.00	0.00	0.00	0.00
948	2018079075350	02/28/18 - 03/04/18	03/26/18	0.00	193.00	0.00	0.00	0.00
948	2218085000780	03/06/18 - 03/08/18	04/02/18	0.00	193.00	0.00	0.00	0.00
948	2018086070848	03/21/18 - 03/22/18	04/02/18	0.00	193.00	0.00	0.00	0.00
948	2018093094909	03/27/18 - 03/30/18	04/09/18	0.00	193.00	0.00	0.00	0.00
948	2018096073607	03/21/18 - 03/23/18	04/16/18	0.00	193.00	0.00	0.00	0.00
948	2018107073226	03/28/18 - 04/02/18	04/23/18	0.00	193.00	0.00	0.00	0.00
948	2018122080677	04/23/18 - 04/28/18	05/07/18	0.00	193.00	0.00	0.00	0.00
948	2018122080830	04/25/18 - 04/28/18	05/07/18	0.00	193.00	0.00	0.00	0.00
948	2018130106622	04/25/18 - 05/03/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2018130106806	05/01/18 - 05/03/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2218131007205	04/25/18 - 04/28/18	05/14/18	0.00	193.00	0.00	0.00	0.00
948	2018137094609	05/08/18 - 05/10/18	05/21/18	0.00	193.00	0.00	0.00	0.00
948	2018141033111	05/10/18 - 05/15/18	05/28/18	0.00	193.00	0.00	0.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

948	2018150000348	05/16/18 - 05/22/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018150000465	05/18/18 - 05/22/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018150000634	05/20/18 - 05/23/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018151025421	05/08/18 - 05/12/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018151025470	04/12/18 - 04/18/18	06/04/18	0.00	193.00	0.00	0.00	0.00
948	2018165022642	05/30/18 - 06/08/18	06/18/18	0.00	193.00	0.00	0.00	0.00
948	2018166000891	06/04/18 - 06/11/18	06/18/18	0.00	193.00	0.00	0.00	0.00
948	2018170033224	06/11/18 - 06/13/18	06/25/18	0.00	193.00	0.00	0.00	0.00
-1	2318171000266	04/15/18 - 04/21/18	07/02/18	0.00	772.00	0.00	2,663.18	0.00
948	2018172000997	06/08/18 - 06/13/18	06/25/18	0.00	386.00	0.00	0.00	0.00
948	2018177022466	06/15/18 - 06/20/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2018179079209	06/22/18 - 06/25/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2218183000197	05/29/18 - 06/11/18	07/09/18	0.00	193.00	0.00	0.00	0.00
948	2018184093280	06/11/18 - 06/12/18	07/09/18	0.00	193.00	0.00	0.00	0.00
948	2218194003625	06/25/18 - 06/28/18	07/16/18	0.00	193.00	0.00	0.00	0.00
948	2218264003496	04/17/18 - 04/24/18	09/24/18	0.00	193.00	0.00	0.00	0.00
948	2218299014615	04/18/18 - 04/30/18	10/29/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	13,124.00	0.00	5,632.17	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	619,905.28	ADJUSTMENTS	0.00
COVERED CHARGES	603,963.32	CONTRACTUAL ALLOW	259,350.80
NON-COVERD CHARGES	15,941.96	TOTAL MEDICAID LIAB	344,612.52
		LESS: COB	344,612.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	73	0	73,073.00	12,799.15
ROUTINE NURSERY	6	0	14,400.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	79	0	87,473.00	12,799.15
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	14	0	34,011.60	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	14	0	34,011.60	0.00
TOTAL ACCOMODATIONS	93	0	121,484.60	12,799.15

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,272.60	0.00	OTHER LAB	4,480.45	0.00
MED/SURG SUPPLY	8,439.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	62,822.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,476.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,029.00	1,172.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,850.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,130.00	0.00	MRI SERVICES	8,917.00	0.00
IV THERAPY	10,688.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,304.24	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,244.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,792.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,998.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,937.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,139.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,492.00	0.00	INJECTABLE DRUGS	145,371.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,616.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,632.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	572.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,695.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,733.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,482.00	1,351.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,833.75	618.75			
AUDIOLOGY	833.00	0.00			
CARDIOLOGY	4,208.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,460.54	0.00			

TOTAL ANCILLARY	482,478.72	3,142.81
TOTAL ACCOMODATIONS	121,484.60	12,799.15
TOTAL CHARGES	603,963.32	15,941.96

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,419,353.64	ADJUSTMENTS	602,362.19
COVERED CHARGES	19,090,862.18	CONTRACTUAL ALLOW	15,902,215.73
NON-COVERD CHARGES	2,328,491.46	TOTAL MEDICAID LIAB	3,188,646.45
		LESS: COB	5,216.61
		LESS: COPAYMENT	7,874.89
		REIMBURSEMENT	3,175,554.95
		ALL OTHER	2,827,445.20
		FEE SCHEDULE-LAB	245,423.10
		INJECTABLE DRUGS	102,686.65

TOTAL NUMBER OF CLAIMS 6,343

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
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	327,314.18	766.90	OTHER LAB	482,218.95	23,257.30
MED/SURG SUPPLY	265,335.06	40,515.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,022,843.13	76,934.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,585,992.00	211,933.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	201,886.53	42,008.16	FEE SCHEDULE LAB	2,702,541.46	155,326.76
EKG/ECG	544,625.00	3,912.50	MRI SERVICES	241,850.00	43,924.00
IV THERAPY	921,518.82	55,767.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,556.02	401,134.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162,168.76	44,077.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	346,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	46,203.00	23,865.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,737,017.79	14,782.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	487,521.00	16,400.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	548,912.20	502,713.10
RADIOLOGY THERAPEUTIC	190,446.86	9,656.69	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,742.25	18,233.95	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,521.50	13,112.77	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,516.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,882.00	11,064.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,442.52	112,035.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	772.00
OTHER IMAGING SERVICE	860,313.75	130,729.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,307.00	48,767.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	129,271.00	180,660.75			
AUDIOLOGY	4,448.50	344.25			
CARDIOLOGY	214,036.75	67,770.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,506.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	633,943.90	53,510.74			

TOTAL ANCILLARY	19,090,862.18	2,328,491.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,090,862.18	2,328,491.46

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 07/01/17 THROUGH 06/30/18
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	9818063000326	07/17/17 - 07/17/17	03/12/18	0.00	193.00	0.00	0.00	0.00
-1	2318218000112	01/03/18 - 01/03/18	08/27/18	0.00	193.00	0.00	0.00	0.00
-1	2318218000112	01/04/18 - 01/04/18	08/27/18	0.00	193.00	0.00	0.00	0.00
-1	2218219001070	05/22/18 - 05/22/18	08/20/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	772.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	359,110.66	ADJUSTMENTS	0.00
COVERED CHARGES	261,607.08	CONTRACTUAL ALLOW	120,548.03
NON-COVERD CHARGES	97,503.58	TOTAL MEDICAID LIAB	141,059.05
		LESS: COB	140,979.26
		LESS: COPAYMENT	79.79
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,329.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,348.20	2,939.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,341.00	3,489.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,178.00	10,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,968.18	1,073.90
EKG/ECG	4,851.50	0.00	MRI SERVICES	1,497.00	1,497.00
IV THERAPY	17,030.05	609.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,144.07	29,045.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,506.53	212.57	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,432.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,565.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,842.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,970.40	3,612.90
RADIOLOGY THERAPEUTIC	2,233.96	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	302.45	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,389.60	17,476.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,112.25	12,040.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,948.25	5,391.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,627.00	6,696.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,986.91	1,381.00			

TOTAL ANCILLARY	261,607.08	97,503.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	261,607.08	97,503.58

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	406,535.63	ADJUSTMENTS	703.22
COVERED CHARGES	399,479.23	CONTRACTUAL ALLOW	382,305.65
NON-COVERD CHARGES	7,056.40	TOTAL MEDICAID LIAB	17,173.58
		LESS: COB	0.00
		LESS: COPAYMENT	600.00
		REIMBURSEMENT	16,573.58
		TOTAL NUMBER OF CLAIMS	307

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
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,627.10	0.00	OTHER LAB	3,654.60	0.00
MED/SURG SUPPLY	270.53	384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,899.00	2,277.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,530.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,233.72	1,562.00
EKG/ECG	3,677.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,656.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	637.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	286,757.15	781.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,546.30	332.90
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,544.50	1,719.50			
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	444.46	0.00			

TOTAL ANCILLARY	399,479.23	7,056.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	399,479.23	7,056.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,030.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,465.50	CONTRACTUAL ALLOW	16,625.18
NON-COVERD CHARGES	565.00	TOTAL MEDICAID LIAB	9,840.32
		LESS: COB	9,822.32
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.60	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	1,727.00	496.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,203.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,712.00	69.00
EKG/ECG	1,565.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,122.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	14,457.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	552.70	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,465.50	565.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,465.50	565.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,461,786.40	ADJUSTMENTS	56,201.00
COVERED CHARGES	3,129,719.08	CONTRACTUAL ALLOW	2,702,044.28
NON-COVERD CHARGES	332,067.32	TOTAL MEDICAID LIAB	427,674.80
		LESS: COB	0.00
		LESS: COPAYMENT	839.42
		REIMBURSEMENT	426,835.38

TOTAL NUMBER OF CLAIMS 76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,355.18	349.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47,232.21	4,343.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,221.00	9,323.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,654.00	10,515.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,725.05	FEE SCHEDULE LAB	108,155.92	5,907.55
EKG/ECG	6,651.25	782.50	MRI SERVICES	0.00	0.00
IV THERAPY	170,844.53	7,703.46	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	217,823.91	36,816.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,884.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,451.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,893,307.60	186,187.90
RADIOLOGY THERAPEUTIC	125,047.38	13,284.24	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	695.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,380.15	5,235.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	183,711.66	21,484.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,468.75	10,502.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,710.00	6,531.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,362.50	4,375.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,228.00	5,454.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,877.55	850.82			

TOTAL ANCILLARY	3,129,719.08	332,067.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,129,719.08	332,067.32

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	102,157.17	ADJUSTMENTS	0.00
COVERED CHARGES	79,593.99	CONTRACTUAL ALLOW	36,806.07
NON-COVERD CHARGES	22,563.18	TOTAL MEDICAID LIAB	42,787.92
		LESS: COB	42,754.92
		LESS: COPAYMENT	33.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,622.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	388.80	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	1,335.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,851.86	779.78	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,034.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	62,743.90	21,341.80
RADIOLOGY THERAPEUTIC	2,617.32	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	441.60	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	79,593.99	22,563.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,593.99	22,563.18

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,702,610.22	ADJUSTMENTS	101,022.36
COVERED CHARGES	10,966,562.53	CONTRACTUAL ALLOW	6,481,180.85
NON-COVERD CHARGES	736,047.69	TOTAL MEDICAID LIAB	4,485,381.68
		LESS: COB	51,074.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,434,306.80

TOTAL NUMBER OF ADMISSIONS 526

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,819	0	1,820,819.00	512,654.06
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,819	0	1,820,819.00	512,654.06
SPECIAL CARE SERVICES				
CCU	7	0	9,752.80	0.00
ICU	269	0	772,704.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	276	0	782,457.60	0.00
TOTAL ACCOMODATIONS	2,095	0	2,603,276.60	512,654.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	781,391.70	0.00	OTHER LAB	106,112.25	0.00
MED/SURG SUPPLY	161,966.13	226.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,621,474.64	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	269,873.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	545,671.00	2,812.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	124,868.72	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	154,074.25	0.00	MRI SERVICES	63,266.00	0.00
IV THERAPY	447,597.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	428,934.57	1,527.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806,825.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	87,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	46,982.00	1,208.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,627.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	30,530.00	0.00	INJECTABLE DRUGS	722,263.89	0.00
RADIOLOGY THERAPEUTIC	4,634.37	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,033.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,841.33	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	25,424.00	60,836.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,083.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	76,269.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,158.00
OTHER IMAGING SERVICE	87,456.81	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,757.00	141,769.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	144,554.50	13,855.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	224,980.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,651.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	125,474.60	0.00			

TOTAL ANCILLARY	8,363,285.93	223,393.63
TOTAL ACCOMODATIONS	2,603,276.60	512,654.06
TOTAL CHARGES	10,966,562.53	736,047.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2018114003102	04/17/18 - 04/19/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2018115068850	03/31/18 - 04/04/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2218117002046	03/24/18 - 03/26/18	04/30/18	0.00	193.00	0.00	0.00	0.00
948	2018155039426	05/28/18 - 05/30/18	06/11/18	0.00	193.00	0.00	0.00	0.00
948	2018178005802	06/16/18 - 06/21/18	07/02/18	0.00	193.00	0.00	0.00	0.00
948	2218201001601	05/26/18 - 06/13/18	07/23/18	0.00	193.00	0.00	0.00	0.00
TOTAL				0.00	1,158.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,396.01	ADJUSTMENTS	0.00
COVERED CHARGES	31,930.64	CONTRACTUAL ALLOW	9,625.96
NON-COVERD CHARGES	4,465.37	TOTAL MEDICAID LIAB	22,304.68
		LESS: COB	22,304.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,005.00	1,762.25
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	5,005.00	1,762.25
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	5,005.00	1,762.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,416.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	306.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,291.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,406.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	782.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,897.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	655.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,498.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,487.70	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	98.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	174.00	2,703.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,948.80	0.00			

TOTAL ANCILLARY	26,925.64	2,703.12
TOTAL ACCOMODATIONS	5,005.00	1,762.25
TOTAL CHARGES	31,930.64	4,465.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,012,297.44	ADJUSTMENTS	337,571.17
COVERED CHARGES	12,158,131.77	CONTRACTUAL ALLOW	10,153,976.87
NON-COVERD CHARGES	854,165.67	TOTAL MEDICAID LIAB	2,004,154.90
		LESS: COB	2,868.03
		LESS: COPAYMENT	3,633.00
		REIMBURSEMENT	1,997,653.87
		ALL OTHER	1,817,733.03
		FEE SCHEDULE-LAB	149,197.72
		INJECTABLE DRUGS	30,723.12

TOTAL NUMBER OF CLAIMS 4,735

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,992.40	661.40	OTHER LAB	211,387.25	0.00
MED/SURG SUPPLY	98,586.97	7,785.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	756,426.50	41,790.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,042,055.00	166,746.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	151,913.02	37,682.86	FEE SCHEDULE LAB	1,839,739.41	76,062.88
EKG/ECG	383,282.81	1,173.75	MRI SERVICES	140,622.00	25,348.00
IV THERAPY	787,937.81	64,385.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	354,406.51	113,683.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79,944.93	5,539.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,957.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,347.00	11,152.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,685,450.06	14,593.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,686.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	243,487.60	37,561.90
RADIOLOGY THERAPEUTIC	45,450.60	18,162.84	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,045.25	10,345.62	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,170.00	2,149.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	12,712.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	883.20	7,186.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,705.74	21,492.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516,258.50	90,452.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,668.00	6,757.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,450.25	44,952.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,635.75	7,934.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	232,389.71	26,167.60			

TOTAL ANCILLARY	12,158,131.77	854,165.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,158,131.77	854,165.67

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	202,172.88	ADJUSTMENTS	0.00
COVERED CHARGES	157,714.55	CONTRACTUAL ALLOW	68,698.43
NON-COVERD CHARGES	44,458.33	TOTAL MEDICAID LIAB	89,016.12
		LESS: COB	88,992.12
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,146.70	0.00	OTHER LAB	1,166.25	0.00
MED/SURG SUPPLY	1,799.00	549.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,692.50	3,142.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,942.00	11,934.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,569.72	998.00
EKG/ECG	3,130.00	0.00	MRI SERVICES	0.00	3,810.00
IV THERAPY	14,210.89	613.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,403.07	4,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	922.64	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,004.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,208.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,921.88	1,547.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,700.90	359.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	98.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	450.00	2,952.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,252.50	12,746.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,402.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	157,714.55	44,458.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	157,714.55	44,458.33

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	609,812.29	ADJUSTMENTS	1,126.74
COVERED CHARGES	597,056.82	CONTRACTUAL ALLOW	572,331.34
NON-COVERD CHARGES	12,755.47	TOTAL MEDICAID LIAB	24,725.48
		LESS: COB	0.00
		LESS: COPAYMENT	705.00
		REIMBURSEMENT	24,020.48
		TOTAL NUMBER OF CLAIMS	442

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,695.40	0.00	OTHER LAB	2,332.50	0.00
MED/SURG SUPPLY	1,959.92	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,816.50	3,575.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,275.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87,727.46	1,658.00
EKG/ECG	7,277.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,330.14	612.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,826.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	415,042.65	1,646.73	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,082.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,288.00	764.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,660.00	800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,665.00	1,248.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,079.00	0.00			

TOTAL ANCILLARY	597,056.82	12,755.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	597,056.82	12,755.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,667.53	ADJUSTMENTS	0.00
COVERED CHARGES	20,487.42	CONTRACTUAL ALLOW	8,356.48
NON-COVERD CHARGES	4,180.11	TOTAL MEDICAID LIAB	12,130.94
		LESS: COB	12,118.94
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145.30	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	1,980.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,774.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,029.86	204.61	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,718.31	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	168.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	671.25	2,027.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,487.42	4,180.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,487.42	4,180.11

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,904.80	ADJUSTMENTS	0.00
COVERED CHARGES	79,367.69	CONTRACTUAL ALLOW	67,769.43
NON-COVERD CHARGES	4,537.11	TOTAL MEDICAID LIAB	11,598.26
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,592.26

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

DEKALB MEDICAL CENTER AT HILLANDALE
2801 DEKALB MEDICAL PKWY
LITHONIA,GA 30058-4996

PROVIDER NUMBER
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,376.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	529.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	292.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,203.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	532.50	FEE SCHEDULE LAB	1,756.00	785.00
EKG/ECG	782.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	408.08	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,318.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,404.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,767.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	403.40	0.00
RADIOLOGY THERAPEUTIC	30,446.29	1,868.05	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	872.00	1,351.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,478.40	0.00			

TOTAL ANCILLARY	79,367.69	4,537.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,367.69	4,537.11

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,594,435.20	ADJUSTMENTS	8,006,543.48
COVERED CHARGES	135,238,434.76	CONTRACTUAL ALLOW	117,767,713.88
NON-COVERD CHARGES	4,356,000.44	TOTAL MEDICAID LIAB	17,470,720.88
		LESS: COB	85,584.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,385,136.50

TOTAL NUMBER OF ADMISSIONS 950

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,200	0	2,251,629.00	1,252,485.28
ROUTINE NURSERY	204	0	230,837.00	105,551.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,404	0	2,482,466.00	1,358,036.28
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2,196	0	7,372,717.00	0.00
NICU	1	0	4,062.00	0.00
PED ICU	3	0	11,172.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	9	0	49,800.00	0.00
BURN UNIT	1,117	0	11,021,386.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,326	0	18,459,137.00	0.00
TOTAL ACCOMODATIONS	5,730	0	20,941,603.00	1,358,036.28

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,242,515.06	408,863.37	OTHER LAB	578,205.32	0.00
MED/SURG SUPPLY	19,991,709.76	255,751.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,256,157.55	16,110.16	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,406,242.95	0.00	OTHER THERAPEUTIC SVC	0.00	1,523.16
CT SCAN	2,454,378.32	512,456.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	941,601.44	439.63	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	467,060.09	0.00	MRI SERVICES	531,088.81	0.00
IV THERAPY	24,913.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,256,883.83	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	261,735.38	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,467,123.58	457.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,638.93	0.00	AMBULANCE	0.00	0.00
GI SERVICES	339,092.53	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,247,785.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,417,770.12	164.50	DRUG-SPECIFIC/HOME IV	0.00	118,336.74
LABORATORY PATHOLOGIC	391,270.95	0.00	INJECTABLE DRUGS	24,419,654.95	65,898.59
RADIOLOGY THERAPEUTIC	103,709.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,359,807.26	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	176,334.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	787,971.45	12,497.76	PATIENT CONVENIENCE	0.00	1,008.72
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,723.52	49,125.66	TRAUMA RESPONSE	0.00	66,902.40
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	906,754.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	517,606.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	666,539.36	1,472,503.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	302,159.71	15,924.31			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,426,275.61	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	125,864.78	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	170,257.13	0.00			

TOTAL ANCILLARY	114,296,831.76	2,997,964.16
TOTAL ACCOMODATIONS	20,941,603.00	1,358,036.28
TOTAL CHARGES	135,238,434.76	4,356,000.44

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 04/01/17 THROUGH 03/31/18
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	2017251089461	05/23/17 - 06/13/17	09/18/17	0.00	0.00	0.00	0.00	0.00
24	2018082082003	09/28/17 - 10/09/17	04/02/18	0.00	0.00	0.00	0.00	0.00
24	2018110068143	03/16/18 - 03/28/18	04/30/18	0.00	0.00	0.00	0.00	0.00
24	2018135062347	01/18/18 - 01/30/18	05/21/18	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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,490.91	ADJUSTMENTS	0.00
COVERED CHARGES	47,705.91	CONTRACTUAL ALLOW	33,498.25
NON-COVERD CHARGES	15,785.00	TOTAL MEDICAID LIAB	14,207.66
		LESS: COB	14,207.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	5,080.00	15,785.00
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	5,080.00	15,785.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	5,080.00	15,785.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,435.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,298.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,372.63	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	25,657.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	655.59	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,457.19	0.00	INJECTABLE DRUGS	9,609.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140.16	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	42,625.91	0.00
TOTAL ACCOMODATIONS	5,080.00	15,785.00
TOTAL CHARGES	47,705.91	15,785.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF AUGUSTA, LLC
3651 WHEELER RD
AUGUSTA,GA 30909-6521

PROVIDER NUMBER
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,321,552.28	ADJUSTMENTS	55,420.88
COVERED CHARGES	20,378,328.29	CONTRACTUAL ALLOW	18,822,771.00
NON-COVERD CHARGES	3,943,223.99	TOTAL MEDICAID LIAB	1,555,557.29
		LESS: COB	2,823.33
		LESS: COPAYMENT	5,079.18
		REIMBURSEMENT	1,547,654.78
		ALL OTHER	1,425,406.37
		FEE SCHEDULE-LAB	108,729.47
		INJECTABLE DRUGS	13,518.94

TOTAL NUMBER OF CLAIMS 4,609

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220,420.23	76,857.14	OTHER LAB	84,216.49	0.00
MED/SURG SUPPLY	1,887,236.65	78,870.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	555,466.38	175,041.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,216,981.23	400,755.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	107,940.69	75,214.31	FEE SCHEDULE LAB	1,457,845.10	105,891.58
EKG/ECG	411,819.35	0.00	MRI SERVICES	145,241.14	64,499.94
IV THERAPY	631,562.95	99,504.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,911,289.78	1,455,334.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	345,500.32	20,805.64	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130,905.65	1,402.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,800.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	227,509.39	89,714.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,714,200.83	21,373.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,596,556.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	992.85
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	513,508.45	361,939.80
RADIOLOGY THERAPEUTIC	470,490.22	150,069.78	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,335.80	55,913.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	706.52	2,570.97	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,562.22	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	332,432.21	48,138.46	TRAUMA RESPONSE	0.00	61,851.20
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,346.00	1,481.75
LITHOTRIPSY	59,057.31	61,869.56	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	388,764.00	124,580.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,186.10	7,497.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,311.59	254,983.43			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,372.77	59,858.40			
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	589,324.62	84,650.65			

TOTAL ANCILLARY	20,378,328.29	3,943,223.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,378,328.29	3,943,223.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	503,384.33	ADJUSTMENTS	0.00
COVERED CHARGES	320,550.31	CONTRACTUAL ALLOW	212,051.04
NON-COVERD CHARGES	182,834.02	TOTAL MEDICAID LIAB	108,499.27
		LESS: COB	108,467.31
		LESS: COPAYMENT	31.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,296.61	987.81	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,774.76	675.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,292.79	5,328.07	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,806.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,336.87	2,965.19
EKG/ECG	9,540.97	0.00	MRI SERVICES	0.00	9,854.80
IV THERAPY	5,285.24	1,650.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,497.20	99,550.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,362.49	10,108.40	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	556.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,983.07	14,473.41	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,159.07	570.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,781.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,390.11	3,107.80
RADIOLOGY THERAPEUTIC	13,678.77	13,215.81	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,589.35	190.66	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,806.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,511.90	10,348.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,707.04	0.00			

TOTAL ANCILLARY	320,550.31	182,834.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320,550.31	182,834.02

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,082,394.95	ADJUSTMENTS	52.94
COVERED CHARGES	921,869.59	CONTRACTUAL ALLOW	899,493.59
NON-COVERD CHARGES	160,525.36	TOTAL MEDICAID LIAB	22,376.00
		LESS: COB	0.00
		LESS: COPAYMENT	642.34
		REIMBURSEMENT	21,733.66
		TOTAL NUMBER OF CLAIMS	400

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,994.51	3,282.91	OTHER LAB	862.98	0.00
MED/SURG SUPPLY	16,720.75	195.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,776.21	14,271.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,155.03	67,402.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	419.00	FEE SCHEDULE LAB	91,572.49	8,174.35
EKG/ECG	23,088.49	0.00	MRI SERVICES	0.00	9,642.62
IV THERAPY	56,473.49	2,809.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,037.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,213.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	418,053.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,930.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,678.89	30,288.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	399.72	TRAUMA RESPONSE	0.00	9,800.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,155.82	12,011.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,264.90	1,828.54			
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	6,891.41	0.00			

TOTAL ANCILLARY	921,869.59	160,525.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,869.59	160,525.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,813.33	ADJUSTMENTS	0.00
COVERED CHARGES	3,170.61	CONTRACTUAL ALLOW	1,610.11
NON-COVERD CHARGES	642.72	TOTAL MEDICAID LIAB	1,560.50
		LESS: COB	1,554.50
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 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	589.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	920.17	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	2,250.44	0.00	SPECIAL SERVICES	0.00	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	53.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,170.61	642.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,170.61	642.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	467,226.16	ADJUSTMENTS	0.00
COVERED CHARGES	456,862.54	CONTRACTUAL ALLOW	434,499.46
NON-COVERD CHARGES	10,363.62	TOTAL MEDICAID LIAB	22,363.08
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	22,315.08

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,787.79	1,038.93	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,352.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957.60	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	1,589.77	60.74
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	713.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,151.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	22,200.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,256.06	1,632.02
RADIOLOGY THERAPEUTIC	277,628.33	7,631.93	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	55,564.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,661.12	0.00			

TOTAL ANCILLARY	456,862.54	10,363.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	456,862.54	10,363.62

GEORGIA DEPARTMENT OF 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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,473,539.63	ADJUSTMENTS	9,681.27
COVERED CHARGES	3,363,967.81	CONTRACTUAL ALLOW	2,143,239.48
NON-COVERD CHARGES	109,571.82	TOTAL MEDICAID LIAB	1,220,728.33
		LESS: COB	8,445.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,212,282.94

TOTAL NUMBER OF ADMISSIONS 177

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	843	0	632,250.00	93,350.00
ROUTINE NURSERY	21	0	9,135.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	3,950.00
TOTAL ROUTINE	864	0	641,385.00	97,300.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	106	0	154,760.00	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	106	0	154,760.00	0.00
TOTAL ACCOMODATIONS	970	0	796,145.00	97,300.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	278,424.67	0.00	OTHER LAB	4,131.61	0.00
MED/SURG SUPPLY	231,002.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	410,822.94	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,676.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	139,625.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,534.64	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,926.06	0.00	MRI SERVICES	2,101.20	0.00
IV THERAPY	70,547.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,792.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,074.29	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	550,067.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,544.58	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,267.52	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,414.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,476.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,323.78	0.00	INJECTABLE DRUGS	148,881.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	268.65	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,234.82	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,117.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,941.65	11,957.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,227.87	313.97			
AUDIOLOGY	4,551.57	0.00			
CARDIOLOGY	18,529.85	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,314.88	0.00			

TOTAL ANCILLARY	2,567,822.81	12,271.82
TOTAL ACCOMODATIONS	796,145.00	97,300.00
TOTAL CHARGES	3,363,967.81	109,571.82

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,480,343.05	ADJUSTMENTS	111,717.71
COVERED CHARGES	3,331,311.61	CONTRACTUAL ALLOW	2,743,195.66
NON-COVERD CHARGES	149,031.44	TOTAL MEDICAID LIAB	588,115.95
		LESS: COB	1,236.53
		LESS: COPAYMENT	2,075.98
		REIMBURSEMENT	584,803.44
		ALL OTHER	514,700.08
		FEE SCHEDULE-LAB	67,002.09
		INJECTABLE DRUGS	3,101.27

TOTAL NUMBER OF CLAIMS 1,874

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,883.92	287.31	OTHER LAB	136,875.27	1,969.65
MED/SURG SUPPLY	174,561.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	69.33	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	195,496.14	5,930.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	507,236.05	7,938.97	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,621.87	1,699.73	FEE SCHEDULE LAB	628,724.07	31,652.95
EKG/ECG	76,145.93	5,564.13	MRI SERVICES	105,899.78	0.00
IV THERAPY	188,125.69	10,490.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	130,463.72	33,342.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,684.16	6,784.80	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,724.58	4,114.81	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	116,655.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,286.91	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	652,467.80	1,242.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,903.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,207.36	11,496.86
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	2,249.61	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,391.62	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,350.87	1,981.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,422.74	2,391.57			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,515.02	5,474.83			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,640.56	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	45,027.95	14,348.94			

TOTAL ANCILLARY	3,331,311.61	149,031.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,331,311.61	149,031.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	68,025.20	ADJUSTMENTS	0.00
COVERED CHARGES	65,283.69	CONTRACTUAL ALLOW	38,806.58
NON-COVERD CHARGES	2,741.51	TOTAL MEDICAID LIAB	26,477.11
		LESS: COB	26,459.11
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334.00	6.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	610.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,208.59	249.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,873.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,935.87	932.58
EKG/ECG	1,560.05	312.01	MRI SERVICES	8,343.60	0.00
IV THERAPY	4,081.20	148.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,470.57	951.92	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	14,508.22	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	804.20	24.89
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	115.36	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	553.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	65,283.69	2,741.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	65,283.69	2,741.51

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	195,021.72	ADJUSTMENTS	4,090.29
COVERED CHARGES	192,923.89	CONTRACTUAL ALLOW	180,366.50
NON-COVERD CHARGES	2,097.83	TOTAL MEDICAID LIAB	12,557.39
		LESS: COB	0.00
		LESS: COPAYMENT	414.00
		REIMBURSEMENT	12,143.39
		TOTAL NUMBER OF CLAIMS	200

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,139.76	27.14	OTHER LAB	4,519.31	0.00
MED/SURG SUPPLY	2,990.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,809.38	173.35	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,739.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,476.89	1,605.71
EKG/ECG	2,808.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,474.27	74.30	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	704.52	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	117,518.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,743.30	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	217.33			

TOTAL ANCILLARY	192,923.89	2,097.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	192,923.89	2,097.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,817.44	ADJUSTMENTS	0.00
COVERED CHARGES	10,668.66	CONTRACTUAL ALLOW	6,246.62
NON-COVERD CHARGES	148.78	TOTAL MEDICAID LIAB	4,422.04
		LESS: COB	4,407.04
		LESS: COPAYMENT	15.00
		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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	590.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	381.35	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	2,976.25	148.78
EKG/ECG	312.01	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	5,849.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	102.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,668.66	148.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,668.66	148.78

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

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,418,004.96	ADJUSTMENTS	32,631.18
COVERED CHARGES	2,238,834.96	CONTRACTUAL ALLOW	1,363,166.13
NON-COVERD CHARGES	179,170.00	TOTAL MEDICAID LIAB	875,668.83
		LESS: COB	31,757.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	843,911.13

TOTAL NUMBER OF ADMISSIONS 153

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	472	0	247,422.50	126,949.50
ROUTINE NURSERY	44	0	12,177.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	516	0	259,599.50	126,949.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	100	0	127,140.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	100	0	127,140.00	0.00
TOTAL ACCOMODATIONS	616	0	386,739.50	126,949.50

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,687.75	15,285.00	OTHER LAB	7,616.50	0.00
MED/SURG SUPPLY	174,956.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	387,232.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,084.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,580.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,603.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	35,678.50	0.00	MRI SERVICES	15,032.50	0.00
IV THERAPY	8,136.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	91,133.75	7,242.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,096.50	10,938.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	203,228.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,941.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,506.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,557.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,281.25	0.00	INJECTABLE DRUGS	52,666.50	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	2,455.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,444.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,472.25	10,354.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,678.75	160.00			
AUDIOLOGY	1,565.00	0.00			
CARDIOLOGY	30,986.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,591.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,881.00	8,240.25			

TOTAL ANCILLARY	1,852,095.46	52,220.50
TOTAL ACCOMODATIONS	386,739.50	126,949.50
TOTAL CHARGES	2,238,834.96	179,170.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,528,379.85	ADJUSTMENTS	28,915.08
COVERED CHARGES	3,060,956.81	CONTRACTUAL ALLOW	2,515,197.57
NON-COVERD CHARGES	467,423.04	TOTAL MEDICAID LIAB	545,759.24
		LESS: COB	1,216.77
		LESS: COPAYMENT	1,285.46
		REIMBURSEMENT	543,257.01
		ALL OTHER	466,601.39
		FEE SCHEDULE-LAB	69,652.19
		INJECTABLE DRUGS	7,003.43

TOTAL NUMBER OF CLAIMS 1,691

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,765.32	32,435.25	OTHER LAB	36,352.25	0.00
MED/SURG SUPPLY	82,896.45	466.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	306.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,992.25	46,269.25	OTHER THERAPEUTIC SVC	0.00	393.50
CT SCAN	602,677.50	142,140.00	SPECIAL CHARGES	281.25	0.00
PHYSICAL THERAPY	13,538.75	4.25	FEE SCHEDULE LAB	768,724.43	52,223.50
EKG/ECG	68,167.25	4,417.00	MRI SERVICES	49,024.50	7,412.50
IV THERAPY	83,062.00	18,626.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	99,004.61	52,888.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,796.00	104.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,491.50	10,580.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,803.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	580,485.75	12,831.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,339.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	79,732.00	24,531.50
RADIOLOGY THERAPEUTIC	2,213.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,161.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	290.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	924.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	142.25
OTHER IMAGING SERVICE	44,684.00	6,808.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,458.75	2,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,630.25	19,768.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,161.00	23,677.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	83,512.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,161.00	6,957.00			

TOTAL ANCILLARY	3,060,956.81	467,423.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,060,956.81	467,423.04

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 08/01/17 THROUGH 07/31/18
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
8502	2218062001096	02/06/18 - 02/06/18	03/12/18	0.00	142.25	0.00	0.00	0.00
TOTAL				0.00	142.25	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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,963.96	ADJUSTMENTS	0.00
COVERED CHARGES	7,912.46	CONTRACTUAL ALLOW	3,838.28
NON-COVERD CHARGES	3,051.50	TOTAL MEDICAID LIAB	4,074.18
		LESS: COB	4,067.81
		LESS: COPAYMENT	6.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	284.65	16.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	338.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,139.50	810.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,166.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,522.50	58.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,627.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,912.46	3,051.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,912.46	3,051.50

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	472,011.63	ADJUSTMENTS	2,656.38
COVERED CHARGES	438,311.95	CONTRACTUAL ALLOW	416,651.85
NON-COVERD CHARGES	33,699.68	TOTAL MEDICAID LIAB	21,660.10
		LESS: COB	23.94
		LESS: COPAYMENT	807.00
		REIMBURSEMENT	20,829.16

TOTAL NUMBER OF CLAIMS 374

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,122.50	4,164.00	OTHER LAB	741.50	0.00
MED/SURG SUPPLY	3,314.70	101.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,128.25	9,696.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	104,599.25	7,103.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,787.75	6,850.75
EKG/ECG	8,222.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,825.75	430.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292.25	1,127.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	180,237.00	236.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,726.00	1,432.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,468.25	2,556.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	743.75	0.00			

TOTAL ANCILLARY	438,311.95	33,699.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	438,311.95	33,699.68

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,150.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,117.00	CONTRACTUAL ALLOW	3,653.99
NON-COVERD CHARGES	33.25	TOTAL MEDICAID LIAB	463.01
		LESS: COB	463.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283.00	4.00	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	968.50	29.25
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	1,983.50	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	259.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	623.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,117.00	33.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,117.00	33.25

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	159,495.89	ADJUSTMENTS	5,542.23
COVERED CHARGES	157,933.39	CONTRACTUAL ALLOW	130,207.24
NON-COVERD CHARGES	1,562.50	TOTAL MEDICAID LIAB	27,726.15
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	27,663.15

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,353.00	74.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	900.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,231.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,437.25	151.25
EKG/ECG	334.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,371.75	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	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	1,293.00	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	111,091.00	0.00
RADIOLOGY THERAPEUTIC	2,790.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	819.50	1,337.25			

TOTAL ANCILLARY	157,933.39	1,562.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	157,933.39	1,562.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,135,152.52	ADJUSTMENTS	322,410.15
COVERED CHARGES	26,884,223.10	CONTRACTUAL ALLOW	21,267,169.70
NON-COVERD CHARGES	250,929.42	TOTAL MEDICAID LIAB	5,617,053.40
		LESS: COB	93,425.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,523,627.55

TOTAL NUMBER OF ADMISSIONS 580

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,562	0	2,018,104.00	88,957.00
ROUTINE NURSERY	130	0	57,460.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,692	0	2,075,564.00	88,957.00
SPECIAL CARE SERVICES				
CCU	756	0	1,861,866.00	40,224.00
ICU	368	0	1,321,488.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,124	0	3,183,354.00	40,224.00
TOTAL ACCOMODATIONS	2,816	0	5,258,918.00	129,181.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,037,655.59	27,794.50	OTHER LAB	174,932.00	0.00
MED/SURG SUPPLY	804,248.01	7,897.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,336,436.00	11,889.00	EDUCATION & TRAINING	2,720.00	0.00
RADIOLOGY-DIAGNOSTIC	665,771.00	1,107.00	OTHER THERAPEUTIC SVC	0.00	862.00
CT SCAN	1,687,136.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,123.38	392.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	261,124.00	1,024.00	MRI SERVICES	526,115.00	0.00
IV THERAPY	443,851.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,299,333.00	5,848.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	512,484.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,139,076.00	19,312.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	521,913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,059.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,297,396.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	152,703.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,007.50
LABORATORY PATHOLOGIC	156,497.50	0.00	INJECTABLE DRUGS	566.00	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	49,454.14	1,457.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	904,815.00	17,964.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,312.00	1,518.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,188.00	0.00	IMPL DEV CHARGE PATIENTS	241,081.17	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	471.00
OTHER IMAGING SERVICE	178,433.00	1,876.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	478,017.00	3,354.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	202,517.00	1,701.00			
AUDIOLOGY	23,485.00	0.00			
CARDIOLOGY	1,042,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,507.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	301,697.31	12,274.00			

TOTAL ANCILLARY	21,625,305.10	121,748.42
TOTAL ACCOMODATIONS	5,258,918.00	129,181.00
TOTAL CHARGES	26,884,223.10	250,929.42

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 07/01/17 THROUGH 06/30/18
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	2017305052264	10/22/17 - 10/24/17	11/06/17	0.00	157.00	0.00	0.00	0.00
780	2018005053608	11/05/17 - 11/09/17	01/08/18	0.00	157.00	0.00	0.00	0.00
780	2018045043821	01/18/18 - 02/06/18	02/19/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	471.00	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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	424,384.54	ADJUSTMENTS	0.00
COVERED CHARGES	422,368.54	CONTRACTUAL ALLOW	248,557.98
NON-COVERD CHARGES	2,016.00	TOTAL MEDICAID LIAB	173,810.56
		LESS: COB	173,810.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	36	0	46,512.00	2,016.00
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	36	0	46,512.00	2,016.00
SPECIAL CARE SERVICES				
CCU	6	0	15,084.00	0.00
ICU	16	0	57,456.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	72,540.00	0.00
TOTAL ACCOMODATIONS	58	0	119,052.00	2,016.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,565.25	0.00	OTHER LAB	4,148.00	0.00
MED/SURG SUPPLY	14,680.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	62,778.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,924.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,156.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	338.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,536.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,785.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,119.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,443.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,277.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,173.00	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	6,137.00	0.00			

TOTAL ANCILLARY	303,316.54	0.00
TOTAL ACCOMODATIONS	119,052.00	2,016.00
TOTAL CHARGES	422,368.54	2,016.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,287,095.02	ADJUSTMENTS	297,980.83
COVERED CHARGES	16,132,954.13	CONTRACTUAL ALLOW	13,970,932.05
NON-COVERD CHARGES	1,154,140.89	TOTAL MEDICAID LIAB	2,162,022.08
		LESS: COB	28,414.21
		LESS: COPAYMENT	3,567.00
		REIMBURSEMENT	2,130,040.87
		ALL OTHER	1,849,027.29
		FEE SCHEDULE-LAB	155,801.69
		INJECTABLE DRUGS	125,211.89

TOTAL NUMBER OF CLAIMS 4,389

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,231.75	1,650.00	OTHER LAB	302,503.00	634.00
MED/SURG SUPPLY	170,738.71	3,929.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	134.15	EDUCATION & TRAINING	0.00	75.00
RADIOLOGY-DIAGNOSTIC	984,529.00	11,842.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,897,744.00	232,503.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,302.00	29,263.05	FEE SCHEDULE LAB	2,214,181.52	127,673.81
EKG/ECG	270,732.00	4,608.00	MRI SERVICES	554,588.00	67,235.00
IV THERAPY	841,191.00	56,443.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	746,353.25	61,392.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,240.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81,103.00	78,858.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	298,205.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,250.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,873,007.00	13,772.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,475.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	600,659.75	92,338.25
RADIOLOGY THERAPEUTIC	696.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,875.00	0.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,964.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	39,727.00	11,502.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	47,257.00	72,271.00	IMPL DEV CHARGE PATIENTS	70,842.79	2,079.00
LITHOTRIPSY	0.00	35,958.00	NO CC/INVALID REV CODE	385.00	400.00
OTHER IMAGING SERVICE	505,944.00	62,243.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,748.00	1,765.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	277,021.00	47,970.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	206,983.00	64,152.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,110.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	334,331.36	55,485.00			

TOTAL ANCILLARY	16,132,954.13	1,154,140.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,132,954.13	1,154,140.89

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 07/01/17 THROUGH 06/30/18
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	2018011061688	12/11/17 - 12/11/17	01/15/18	77.00	0.00	0.00	0.00	20.52
780	2018011061688	12/11/17 - 12/11/17	01/15/18	0.00	80.00	0.00	0.00	0.00
780	2018071018043	02/24/18 - 02/24/18	03/19/18	77.00	0.00	0.00	0.00	20.52
780	2018071018043	02/24/18 - 02/24/18	03/19/18	0.00	80.00	0.00	0.00	0.00
780	2018100073119	03/21/18 - 03/21/18	04/16/18	77.00	0.00	0.00	0.00	20.52
780	2018100073119	03/21/18 - 03/21/18	04/16/18	0.00	80.00	0.00	0.00	0.00
780	2018114064488	04/07/18 - 04/07/18	04/30/18	77.00	0.00	0.00	0.00	20.52
780	2018114064488	04/07/18 - 04/07/18	04/30/18	0.00	80.00	0.00	0.00	0.00
780	2018120012700	04/07/18 - 04/07/18	05/07/18	77.00	0.00	0.00	0.00	20.52
780	2018120012700	04/07/18 - 04/07/18	05/07/18	0.00	80.00	0.00	0.00	0.00
TOTAL				385.00	400.00	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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	227,394.33	ADJUSTMENTS	0.00
COVERED CHARGES	185,589.69	CONTRACTUAL ALLOW	94,698.62
NON-COVERD CHARGES	41,804.64	TOTAL MEDICAID LIAB	90,891.07
		LESS: COB	90,882.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,147.00	0.00	OTHER LAB	3,980.00	0.00
MED/SURG SUPPLY	1,293.82	101.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,860.00	4,211.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,826.00	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,495.53	2,127.64
EKG/ECG	5,120.00	512.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,690.00	1,110.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,630.00	9,100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,368.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,031.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,803.00	5,129.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,564.50	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	111.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,765.00	3,946.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	9,414.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,304.00	0.00			

TOTAL ANCILLARY	185,589.69	41,804.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,589.69	41,804.64

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	750,425.50	ADJUSTMENTS	270.70
COVERED CHARGES	723,565.50	CONTRACTUAL ALLOW	705,816.97
NON-COVERD CHARGES	26,860.00	TOTAL MEDICAID LIAB	17,748.53
		LESS: COB	742.77
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	16,507.76
		TOTAL NUMBER OF CLAIMS	304

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,402.25	0.00	OTHER LAB	9,752.00	0.00
MED/SURG SUPPLY	988.00	206.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,258.00	682.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,519.00	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	130,892.00	6,288.00
EKG/ECG	8,192.00	0.00	MRI SERVICES	6,133.00	0.00
IV THERAPY	33,069.00	1,874.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,379.00	2,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	346,458.00	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	233.25	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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,829.00	8,698.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,461.00	2,958.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	723,565.50	26,860.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	723,565.50	26,860.00

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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,106.25	ADJUSTMENTS	0.00
COVERED CHARGES	11,197.25	CONTRACTUAL ALLOW	6,228.53
NON-COVERD CHARGES	2,909.00	TOTAL MEDICAID LIAB	4,968.72
		LESS: COB	4,961.72
		LESS: COPAYMENT	7.00
		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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	2,321.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,015.00	2,909.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,197.25	2,909.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,197.25	2,909.00

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,089,579.31	ADJUSTMENTS	49,215.12
COVERED CHARGES	1,071,191.81	CONTRACTUAL ALLOW	939,559.49
NON-COVERD CHARGES	18,387.50	TOTAL MEDICAID LIAB	131,632.32
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	131,407.32
		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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,842.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,769.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,678.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,445.00	0.00
EKG/ECG	1,536.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,311.00	2,404.00	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	65,280.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,878.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,346.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	793,570.00	2,425.50
RADIOLOGY THERAPEUTIC	696.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,027.00	0.00
LITHOTRIPSY	35,958.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,493.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,700.00	8,643.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,630.00	4,915.00			

TOTAL ANCILLARY	1,071,191.81	18,387.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,071,191.81	18,387.50

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

WELLSTAR DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	86,657.43	ADJUSTMENTS	0.00
COVERED CHARGES	72,382.91	CONTRACTUAL ALLOW	45,096.18
NON-COVERD CHARGES	14,274.52	TOTAL MEDICAID LIAB	27,286.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,286.73

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	19	0	10,638.00	7,412.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	10,638.00	7,412.00
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	10,638.00	7,412.00

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,405.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	955.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,594.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	809.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,318.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	130.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,986.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	10,972.30	0.00	SPECIAL SERVICES	0.00	353.72
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,573.44	6,508.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	61,744.91	6,862.52
TOTAL ACCOMODATIONS	10,638.00	7,412.00
TOTAL CHARGES	72,382.91	14,274.52

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	852,967.45	ADJUSTMENTS	37,036.52
COVERED CHARGES	702,694.83	CONTRACTUAL ALLOW	497,968.86
NON-COVERD CHARGES	150,272.62	TOTAL MEDICAID LIAB	204,725.97
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	204,656.97
		ALL OTHER	192,278.60
		FEE SCHEDULE-LAB	12,273.89
		INJECTABLE DRUGS	104.48

TOTAL NUMBER OF CLAIMS 500

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,385.72	9,710.90	OTHER LAB	23,633.90	0.00
MED/SURG SUPPLY	7,423.84	430.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,153.79	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,952.76	18,351.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,459.10	76,260.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	535.62	FEE SCHEDULE LAB	280,917.79	20,861.32
EKG/ECG	2,794.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	984.00	PROFESSIONAL FEES	0.00	552.00
OPERATING ROOM	1,093.84	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,283.74	513.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	281,532.82	14,007.48	SPECIAL SERVICES	0.00	622.81
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238.00	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	2,328.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,983.20	1,988.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,667.30	0.00			

TOTAL ANCILLARY	702,694.83	150,272.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	702,694.83	150,272.62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	423.54	ADJUSTMENTS	0.00
COVERED CHARGES	5.00	CONTRACTUAL ALLOW	2.80
NON-COVERD CHARGES	418.54	TOTAL MEDICAID LIAB	2.20
		LESS: COB	0.00
		LESS: COPAYMENT	2.20
		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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	14.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	404.54	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5.00	418.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5.00	418.54

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	182,144.18	ADJUSTMENTS	1,101.00
COVERED CHARGES	153,966.77	CONTRACTUAL ALLOW	148,846.77
NON-COVERD CHARGES	28,177.41	TOTAL MEDICAID LIAB	5,120.00
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	4,949.00
		TOTAL NUMBER OF CLAIMS	88

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,151.00	3,281.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,720.95	70.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	74.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,045.40	1,649.62	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,530.60	18,734.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,351.96	3,244.34
EKG/ECG	523.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	368.00	PROFESSIONAL FEES	0.00	524.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	97,611.66	0.00	SPECIAL SERVICES	0.00	109.17
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32.00	122.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	153,966.77	28,177.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	153,966.77	28,177.41

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,488.82	ADJUSTMENTS	0.00
COVERED CHARGES	1,484.82	CONTRACTUAL ALLOW	383.84
NON-COVERD CHARGES	4.00	TOTAL MEDICAID LIAB	1,100.98
		LESS: COB	1,100.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	4.00	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	1,484.82	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,484.82	4.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,484.82	4.00

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,117.64	ADJUSTMENTS	4,862.89
COVERED CHARGES	15,462.30	CONTRACTUAL ALLOW	10,599.41
NON-COVERD CHARGES	3,655.34	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,862.89

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

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	762.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	895.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	404.54	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	3,116.88	2,486.00
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	194.86	0.00	FREE STANDING CLINIC	0.00	0.00
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	407.34
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,680.08	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.80	0.00			

TOTAL ANCILLARY	15,462.30	3,655.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,462.30	3,655.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 11/01/17 THROUGH 10/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	315,487.61	ADJUSTMENTS	24,941.54
COVERED CHARGES	253,114.38	CONTRACTUAL ALLOW	168,231.05
NON-COVERD CHARGES	62,373.23	TOTAL MEDICAID LIAB	84,883.33
		LESS: COB	5,252.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	79,630.38

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	41	0	45,469.00	57,851.00
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	45,469.00	57,851.00
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	41	0	45,469.00	57,851.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,120.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,857.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,773.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,080.53	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,908.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	835.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,353.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,737.00	0.00	PROFESSIONAL FEES	0.00	597.68
OPERATING ROOM	13,864.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,589.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,863.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,502.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,297.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	719.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	896.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,924.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,245.00	0.00			

TOTAL ANCILLARY	207,645.38	4,522.23
TOTAL ACCOMODATIONS	45,469.00	57,851.00
TOTAL CHARGES	253,114.38	62,373.23

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,820.40	ADJUSTMENTS	0.00
COVERED CHARGES	36,710.40	CONTRACTUAL ALLOW	9,110.78
NON-COVERD CHARGES	14,110.00	TOTAL MEDICAID LIAB	27,599.62
		LESS: COB	27,599.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10	0	11,090.00	14,110.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	11,090.00	14,110.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	10	0	11,090.00	14,110.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,298.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	194.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,581.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	438.00	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	3,658.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	450.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,620.40	0.00
TOTAL ACCOMODATIONS	11,090.00	14,110.00
TOTAL CHARGES	36,710.40	14,110.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,661,805.49	ADJUSTMENTS	171,413.02
COVERED CHARGES	3,430,657.88	CONTRACTUAL ALLOW	2,798,518.61
NON-COVERD CHARGES	231,147.61	TOTAL MEDICAID LIAB	632,139.27
		LESS: COB	856.75
		LESS: COPAYMENT	1,225.70
		REIMBURSEMENT	630,056.82
		ALL OTHER	580,014.05
		FEE SCHEDULE-LAB	40,299.12
		INJECTABLE DRUGS	9,743.65

TOTAL NUMBER OF CLAIMS 1,396

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,403.49	5,184.45	OTHER LAB	31,905.56	0.00
MED/SURG SUPPLY	41,147.90	1,196.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	219,355.78	29,837.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	498,482.11	64,153.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,697.57	901.68	FEE SCHEDULE LAB	445,433.44	16,084.14
EKG/ECG	30,937.98	270.71	MRI SERVICES	119,150.64	2,836.00
IV THERAPY	116,212.46	1,642.06	PROFESSIONAL FEES	0.00	66.34
OPERATING ROOM	131,474.91	5,434.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,487.60	8,318.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,278.17	972.00	AMBULANCE	0.00	0.00
GI SERVICES	24,412.85	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	658,732.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,622.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	681,906.31	48,471.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	514.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	163.54	3,076.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,920.00	22,250.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	84,747.01	3,807.03			
BLOOD	971.95	971.95			
BLOOD STORAGE & PRO.	11,677.95	0.00			
ONCOLOGY	69,870.76	0.00			
NUCLEAR MEDICINE	5,769.23	300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,666.71	2,575.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,228.38	12,285.00			

TOTAL ANCILLARY	3,430,657.88	231,147.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,430,657.88	231,147.61

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	63,038.75	ADJUSTMENTS	0.00
COVERED CHARGES	45,727.44	CONTRACTUAL ALLOW	16,572.88
NON-COVERD CHARGES	17,311.31	TOTAL MEDICAID LIAB	29,154.56
		LESS: COB	29,147.04
		LESS: COPAYMENT	7.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,430.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,129.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,872.05	1,989.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,544.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,088.11	412.10
EKG/ECG	475.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,623.38	46.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,300.78	3,274.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,908.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,234.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	683.34	1,046.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	6,201.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,085.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	165.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	45,727.44	17,311.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,727.44	17,311.31

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,759.68	ADJUSTMENTS	429.00
COVERED CHARGES	194,444.35	CONTRACTUAL ALLOW	185,844.35
NON-COVERD CHARGES	4,315.33	TOTAL MEDICAID LIAB	8,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	8,324.00
		TOTAL NUMBER OF CLAIMS	172

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,850.60	165.85	OTHER LAB	972.00	0.00
MED/SURG SUPPLY	490.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,293.99	1,812.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,586.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,382.13	1,154.25
EKG/ECG	812.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,581.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,000.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,565.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,436.38	510.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	474.00	672.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	194,444.35	4,315.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	194,444.35	4,315.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,752.55	ADJUSTMENTS	0.00
COVERED CHARGES	9,184.55	CONTRACTUAL ALLOW	3,141.45
NON-COVERD CHARGES	4,568.00	TOTAL MEDICAID LIAB	6,043.10
		LESS: COB	6,043.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	422.70	0.00	OTHER LAB	972.00	0.00
MED/SURG SUPPLY	56.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,351.07	64.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,224.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,176.00	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	264.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,184.55	4,568.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,184.55	4,568.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	168,790.08	ADJUSTMENTS	6,846.30
COVERED CHARGES	168,534.08	CONTRACTUAL ALLOW	141,136.88
NON-COVERD CHARGES	256.00	TOTAL MEDICAID LIAB	27,397.20
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	27,388.20

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,844.27	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	317.41	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	153,594.50	256.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	10,777.90	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	168,534.08	256.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,534.08	256.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL
459 GA HIGHWAY 119 S
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	258,246.53	ADJUSTMENTS	9,505.38
COVERED CHARGES	252,357.53	CONTRACTUAL ALLOW	104,029.47
NON-COVERD CHARGES	5,889.00	TOTAL MEDICAID LIAB	148,328.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	148,328.06

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	50,464.00	4,011.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	83	0	50,464.00	4,011.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	83	0	50,464.00	4,011.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,264.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,115.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,442.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,438.28	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,110.96	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	491.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,415.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,680.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,798.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,506.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,980.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	200.00	0.00	INJECTABLE DRUGS	44.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	284.48	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	1,878.00
OTHER IMAGING SERVICE	1,457.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	415.11	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,512.93	0.00			
AMBULATORY SURGERY	0.00	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	0.00			

TOTAL ANCILLARY	201,893.53	1,878.00
TOTAL ACCOMODATIONS	50,464.00	4,011.00
TOTAL CHARGES	252,357.53	5,889.00

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 07/01/17 THROUGH 06/30/18
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	2018123071260	04/05/18 - 04/13/18	05/07/18	0.00	1,878.00	0.00	0.00	0.00
TOTAL				0.00	1,878.00	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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,098,376.73	ADJUSTMENTS	50,096.45
COVERED CHARGES	965,638.03	CONTRACTUAL ALLOW	728,699.88
NON-COVERD CHARGES	132,738.70	TOTAL MEDICAID LIAB	236,938.15
		LESS: COB	0.00
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	236,008.15
		ALL OTHER	205,957.53
		FEE SCHEDULE-LAB	28,840.21
		INJECTABLE DRUGS	1,210.41

TOTAL NUMBER OF CLAIMS 805

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,943.35	31,032.35	OTHER LAB	10,892.75	0.00
MED/SURG SUPPLY	15,240.69	3,439.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,884.13	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,337.86	8,592.41	OTHER THERAPEUTIC SVC	0.00	62.00
CT SCAN	116,314.84	23,376.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,781.75	10,378.04	FEE SCHEDULE LAB	206,845.82	6,644.98
EKG/ECG	14,268.00	1,640.00	MRI SERVICES	42,509.49	0.00
IV THERAPY	44,675.24	2,876.57	PROFESSIONAL FEES	0.00	2,335.86
OPERATING ROOM	97,716.70	17,900.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,689.04	2,983.94	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,899.00	796.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	217,779.62	4,266.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,085.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,679.55	2,884.20
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	4,103.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,719.27
OTHER IMAGING SERVICE	24,759.06	2,432.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,160.62	645.82			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,564.65	1,512.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,495.00	1,231.92			

TOTAL ANCILLARY	965,638.03	132,738.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	965,638.03	132,738.70

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 07/01/17 THROUGH 06/30/18
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	2017226019200	07/21/17 - 07/21/17	08/21/17	0.00	1,719.27	0.00	0.00	0.00
TOTAL				0.00	1,719.27	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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,517.23	ADJUSTMENTS	0.00
COVERED CHARGES	3,777.77	CONTRACTUAL ALLOW	3,413.81
NON-COVERD CHARGES	1,739.46	TOTAL MEDICAID LIAB	363.96
		LESS: COB	363.69
		LESS: COPAYMENT	0.27
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180.00	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	2,115.31	353.68
EKG/ECG	0.00	328.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	1,057.78	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,395.46	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	68.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,777.77	1,739.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,777.77	1,739.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	131,498.00	ADJUSTMENTS	856.04
COVERED CHARGES	115,916.55	CONTRACTUAL ALLOW	109,427.51
NON-COVERD CHARGES	15,581.45	TOTAL MEDICAID LIAB	6,489.04
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	6,204.04
		TOTAL NUMBER OF CLAIMS	116

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222.10	1,202.00	OTHER LAB	658.43	0.00
MED/SURG SUPPLY	105.50	151.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,057.76	1,108.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,199.05	11,908.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,091.39	795.68
EKG/ECG	1,312.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,196.38	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	101.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,148.93	319.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,093.00	96.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,430.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	300.00	0.00			

TOTAL ANCILLARY	115,916.55	15,581.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,916.55	15,581.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,238,644.27	ADJUSTMENTS	14,045.40
COVERED CHARGES	4,186,564.27	CONTRACTUAL ALLOW	3,071,976.71
NON-COVERD CHARGES	1,052,080.00	TOTAL MEDICAID LIAB	1,114,587.56
		LESS: COB	25,881.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,088,705.66

TOTAL NUMBER OF ADMISSIONS 188

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,327	0	659,367.00	1,033,369.00
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	1,327	0	659,367.00	1,033,369.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	152	0	167,504.00	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	152	0	167,504.00	0.00
TOTAL ACCOMODATIONS	1,479	0	826,871.00	1,033,369.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,241,217.75	0.00	OTHER LAB	17,983.00	0.00
MED/SURG SUPPLY	82,253.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	690,311.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	94,364.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	289,017.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,576.62	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	45,497.00	0.00	MRI SERVICES	24,388.00	0.00
IV THERAPY	104,650.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,226.00	8,961.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332,756.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	288,791.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,365.00	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	18,186.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,755.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	606.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,359.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,133.00	9,674.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,047.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,855.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,356.00	0.00			

TOTAL ANCILLARY	3,359,693.27	18,711.00
TOTAL ACCOMODATIONS	826,871.00	1,033,369.00
TOTAL CHARGES	4,186,564.27	1,052,080.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,153.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,711.00	CONTRACTUAL ALLOW	4,154.64
NON-COVERD CHARGES	15,442.00	TOTAL MEDICAID LIAB	10,556.36
		LESS: COB	10,556.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	6,958.00	15,442.00
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	6,958.00	15,442.00
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	6,958.00	15,442.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,396.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,278.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	778.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,753.00	0.00
TOTAL ACCOMODATIONS	6,958.00	15,442.00
TOTAL CHARGES	14,711.00	15,442.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,613,826.86	ADJUSTMENTS	39,652.44
COVERED CHARGES	4,384,578.16	CONTRACTUAL ALLOW	3,783,022.02
NON-COVERD CHARGES	229,248.70	TOTAL MEDICAID LIAB	601,556.14
		LESS: COB	1,766.71
		LESS: COPAYMENT	996.00
		REIMBURSEMENT	598,793.43
		ALL OTHER	519,446.14
		FEE SCHEDULE-LAB	79,320.10
		INJECTABLE DRUGS	27.19

TOTAL NUMBER OF CLAIMS 1,825

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380,865.91	91.00	OTHER LAB	17,198.00	0.00
MED/SURG SUPPLY	123,180.00	1,879.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	229.35	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	227,696.00	14,187.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	604,727.00	32,089.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,045,777.25	57,237.35
EKG/ECG	61,650.00	0.00	MRI SERVICES	45,571.00	0.00
IV THERAPY	281,767.00	15,997.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,954.00	4,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,048.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,702.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,691.00	27,938.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128.00	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	1,054.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,124.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	3,634.00	0.00
OTHER IMAGING SERVICE	125,841.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,579.00	4,200.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	32,117.00	31,592.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,496.00	3,690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,484.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200,832.00	31,732.00			

TOTAL ANCILLARY	4,384,578.16	229,248.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,384,578.16	229,248.70

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 07/01/17 THROUGH 06/30/18
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	2017243073996	08/22/17 - 08/22/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042221	09/08/17 - 09/08/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042224	09/01/17 - 09/01/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017262042225	09/01/17 - 09/01/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017275017353	09/15/17 - 09/15/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067922	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067925	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017292067945	10/10/17 - 10/10/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017297040497	10/06/17 - 10/06/17	11/13/17	79.00	0.00	0.00	0.00	20.52
780	2017319065948	10/17/17 - 10/17/17	11/20/17	79.00	0.00	0.00	0.00	20.52
780	2017341067133	11/14/17 - 11/14/17	12/11/17	79.00	0.00	0.00	0.00	20.52
780	2017354069406	10/24/17 - 10/24/17	12/25/17	79.00	0.00	0.00	0.00	20.52
780	2017354069528	11/02/17 - 11/02/17	12/25/17	79.00	0.00	0.00	0.00	20.52
780	2018011070716	12/12/17 - 12/12/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018011070805	12/07/17 - 12/07/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018011070808	12/07/17 - 12/07/17	01/15/18	79.00	0.00	0.00	0.00	20.52
780	2018043024284	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024286	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024287	01/26/18 - 01/26/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024302	01/18/18 - 01/18/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018043024303	02/01/18 - 02/01/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018044072559	01/09/18 - 01/09/18	02/19/18	79.00	0.00	0.00	0.00	20.52
780	2018053066660	02/08/18 - 02/08/18	02/26/18	79.00	0.00	0.00	0.00	20.52
780	2018053066808	02/08/18 - 02/08/18	02/26/18	79.00	0.00	0.00	0.00	20.52
780	2018058041690	02/06/18 - 02/06/18	03/05/18	79.00	0.00	0.00	0.00	20.52
780	2018079070276	03/05/18 - 03/05/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070280	03/06/18 - 03/06/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070291	03/05/18 - 03/05/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018079070294	03/06/18 - 03/06/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018080058662	03/14/18 - 03/14/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018081071333	03/15/18 - 03/15/18	03/26/18	79.00	0.00	0.00	0.00	20.52
780	2018127025067	04/11/18 - 04/11/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025070	04/11/18 - 04/11/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025098	04/05/18 - 04/05/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025106	04/12/18 - 04/12/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018127025107	04/05/18 - 04/05/18	05/14/18	79.00	0.00	0.00	0.00	20.52
780	2018141028100	05/11/18 - 05/11/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018141028103	05/08/18 - 05/08/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018144073319	04/05/18 - 04/05/18	05/28/18	79.00	0.00	0.00	0.00	20.52
780	2018151035356	05/03/18 - 05/03/18	06/04/18	79.00	0.00	0.00	0.00	20.52
780	2018158071304	05/31/18 - 05/31/18	06/11/18	79.00	0.00	0.00	0.00	20.52
780	2018158071672	05/31/18 - 05/31/18	06/11/18	79.00	0.00	0.00	0.00	20.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

780	2018169015133	06/05/18 - 06/05/18	06/25/18	79.00	0.00	0.00	0.00	20.52
780	2018178028890	06/11/18 - 06/11/18	07/02/18	79.00	0.00	0.00	0.00	20.52
780	2018178028891	06/14/18 - 06/14/18	07/02/18	79.00	0.00	0.00	0.00	20.52
780	2018178028898	06/14/18 - 06/14/18	07/02/18	79.00	0.00	0.00	0.00	20.52
TOTAL				3,634.00	0.00	0.00	0.00	943.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,655.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,073.00	CONTRACTUAL ALLOW	23,068.65
NON-COVERD CHARGES	7,582.00	TOTAL MEDICAID LIAB	13,004.35
		LESS: COB	12,998.35
		LESS: COPAYMENT	6.00
		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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,467.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,843.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	640.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,686.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,971.00	202.00
EKG/ECG	598.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,217.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,931.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86.00	485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,073.00	7,582.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,073.00	7,582.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	700,600.40	ADJUSTMENTS	108.88
COVERED CHARGES	678,650.40	CONTRACTUAL ALLOW	659,966.44
NON-COVERD CHARGES	21,950.00	TOTAL MEDICAID LIAB	18,683.96
		LESS: COB	0.00
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	18,095.96
		TOTAL NUMBER OF CLAIMS	334

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,390.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,475.00	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,209.00	2,607.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,310.00	6,688.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	121,654.10	7,914.00
EKG/ECG	5,328.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45,845.00	1,063.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,161.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304,661.00	2,015.00	SPECIAL SERVICES	0.00	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	60.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,605.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,332.00	1,400.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,680.00	0.00			

TOTAL ANCILLARY	678,650.40	21,950.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	678,650.40	21,950.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,644.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,604.00	CONTRACTUAL ALLOW	4,863.34
NON-COVERD CHARGES	3,040.00	TOTAL MEDICAID LIAB	4,740.66
		LESS: COB	4,731.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	654.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	351.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,686.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,299.00	354.00
EKG/ECG	299.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	5,935.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,604.00	3,040.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,604.00	3,040.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV
1364 CLIFTON RD NE DEPT RM
ATLANTA,GA 30322-1059

PROVIDER NUMBER
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	161,544,676.09	ADJUSTMENTS	11,335,064.09
COVERED CHARGES	150,167,453.30	CONTRACTUAL ALLOW	105,566,566.06
NON-COVERD CHARGES	11,377,222.79	TOTAL MEDICAID LIAB	44,600,887.24
		LESS: COB	414,275.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	44,186,612.15

TOTAL NUMBER OF ADMISSIONS 1,783

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,884	0	15,315,254.00	1,984,928.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,884	0	15,315,254.00	1,984,928.00
SPECIAL CARE SERVICES				
CCU	455	0	2,696,960.00	115,292.00
ICU	5,673	0	25,944,163.00	1,201,311.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,128	0	28,641,123.00	1,316,603.00
TOTAL ACCOMODATIONS	17,012	0	43,956,377.00	3,301,531.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,734,075.86	351,767.92	OTHER LAB	667,605.00	26,380.00
MED/SURG SUPPLY	5,611,756.40	716,482.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,056,815.41	1,083,451.00	EDUCATION & TRAINING	59.00	0.00
RADIOLOGY-DIAGNOSTIC	2,011,555.36	98,070.88	OTHER THERAPEUTIC SVC	0.00	7,923.00
CT SCAN	4,242,399.00	145,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	908,170.50	31,094.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	405,506.00	17,248.00	MRI SERVICES	2,007,327.00	30,041.00
IV THERAPY	98.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,594,557.00	421,935.00	DURABLE MED. EQUIP.	0.00	8,905.68
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,184,502.00	251,138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,681,439.00	65,219.00	AMBULANCE	0.00	0.00
GI SERVICES	537,651.00	20,616.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,792,784.00	11,133.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	905,568.00	13,844.00	DRUG-SPECIFIC/HOME IV	0.00	306,605.18
LABORATORY PATHOLOGIC	882,488.00	31,968.00	INJECTABLE DRUGS	20,909,708.26	2,063,065.61
RADIOLOGY THERAPEUTIC	244,947.00	1,659.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	732,741.97	29,796.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	340,936.53	6,278.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,180,572.00	113,240.00	PATIENT CONVENIENCE	0.00	996.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,984.00	503.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	288.00	0.00	IMPL DEV CHARGE PATIENTS	4,766,050.51	181,987.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	414,234.00
OTHER IMAGING SERVICE	294,470.00	222,924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,949,825.00	1,000,823.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,763.00	105,909.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,555,313.00	156,412.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,961,027.00	79,699.00			
ORGAN ACQUISITION	1,807,562.50	48,982.00			
TREATMENT/OBSERV. RM	114,531.00	10,357.00			

TOTAL ANCILLARY	106,211,076.30	8,075,691.79
TOTAL ACCOMODATIONS	43,956,377.00	3,301,531.00
TOTAL CHARGES	150,167,453.30	11,377,222.79

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 09/01/17 THROUGH 08/31/18
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	2017258064347	09/08/17 - 09/10/17	09/25/17	0.00	8,958.00	0.00	0.00	0.00
615	2017283093309	09/26/17 - 09/28/17	10/16/17	0.00	4,479.00	0.00	0.00	0.00
615	2017296023888	09/12/17 - 09/29/17	10/30/17	0.00	8,958.00	0.00	0.00	0.00
615	5217321000384	09/12/17 - 10/12/17	11/27/17	0.00	2,698.00	0.00	0.00	0.00
615	2017326086109	11/16/17 - 11/17/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2217354013386	10/06/17 - 10/11/17	12/25/17	0.00	8,958.00	0.00	0.00	0.00
614	2017361054051	11/30/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
614	2318022000292	09/20/17 - 09/28/17	02/12/18	0.00	8,958.00	0.00	1,303.79	0.00
614	2318022000307	10/01/17 - 10/05/17	02/12/18	0.00	4,479.00	0.00	2,358.54	0.00
615	5218037000002	10/17/17 - 01/01/18	02/12/18	0.00	11,656.00	0.00	0.00	0.00
615	2018045067228	12/17/17 - 12/22/17	02/19/18	0.00	8,958.00	0.00	0.00	0.00
615	2018055067633	02/11/18 - 02/15/18	03/05/18	0.00	8,958.00	0.00	0.00	0.00
615	5218075000386	01/22/18 - 01/30/18	03/26/18	0.00	2,698.00	0.00	0.00	0.00
615	2018081097344	03/11/18 - 03/17/18	03/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018085027475	02/15/18 - 02/23/18	04/02/18	0.00	4,479.00	0.00	0.00	0.00
614	2318093000267	12/25/17 - 01/09/18	04/16/18	0.00	4,479.00	0.00	4,456.93	0.00
615	2018093092107	02/23/18 - 03/26/18	04/09/18	0.00	8,958.00	0.00	0.00	0.00
615	2018103062547	04/03/18 - 04/06/18	04/16/18	0.00	8,958.00	0.00	0.00	0.00
615	2018108085086	11/14/17 - 11/27/17	04/23/18	0.00	8,958.00	0.00	0.00	0.00
614	2018128072711	04/10/18 - 04/19/18	05/14/18	0.00	4,479.00	0.00	0.00	0.00
614	2218129005282	10/28/17 - 11/09/17	05/14/18	0.00	4,479.00	0.00	0.00	0.00
614	2018136069412	11/23/17 - 12/07/17	05/21/18	0.00	4,479.00	0.00	0.00	0.00
615	2018137093798	05/08/18 - 05/12/18	05/21/18	0.00	2,698.00	0.00	0.00	0.00
615	2018144093407	05/13/18 - 05/17/18	05/28/18	0.00	2,698.00	0.00	0.00	0.00
615	2218158004739	04/21/18 - 04/23/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018162022651	06/01/18 - 06/04/18	06/18/18	0.00	8,958.00	0.00	0.00	0.00
615	2218170003816	12/13/17 - 02/01/18	06/25/18	0.00	2,698.00	0.00	0.00	0.00
614	2018172093125	04/23/18 - 05/04/18	06/25/18	0.00	4,636.00	0.00	0.00	0.00
615	2018179078482	05/25/18 - 06/21/18	07/02/18	0.00	2,698.00	0.00	0.00	0.00
614	2018186097450	04/03/18 - 04/20/18	07/09/18	0.00	8,958.00	0.00	0.00	0.00
615	2018191069044	06/07/18 - 07/04/18	07/16/18	0.00	7,177.00	0.00	0.00	0.00
614	5218193000343	10/02/17 - 11/10/17	07/16/18	0.00	2,698.00	0.00	0.00	0.00
615	2218205009924	06/01/18 - 06/06/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
614	2218211003639	03/20/18 - 03/30/18	08/06/18	0.00	4,636.00	0.00	0.00	0.00
615	2018227085376	07/29/18 - 07/31/18	08/20/18	0.00	8,958.00	0.00	0.00	0.00
615	2218229012066	01/02/18 - 03/02/18	08/20/18	0.00	4,479.00	0.00	0.00	0.00
615	2218232004298	07/23/18 - 07/24/18	08/27/18	0.00	4,479.00	0.00	0.00	0.00
615	2018234066138	08/11/18 - 08/17/18	08/27/18	0.00	2,698.00	0.00	0.00	0.00
614	2318239000018	03/26/18 - 04/10/18	09/10/18	0.00	4,479.00	0.00	7,912.31	0.00
615	2018239031483	08/10/18 - 08/20/18	09/03/18	0.00	8,958.00	0.00	0.00	0.00
614	2018241066191	06/22/18 - 07/24/18	09/03/18	0.00	4,479.00	0.00	0.00	0.00
615	5218241000164	05/01/18 - 06/12/18	09/03/18	0.00	4,479.00	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2318278000093	08/16/18 - 08/21/18	10/22/18	0.00	4,479.00	0.00	2,432.72	0.00
618	2318278000093	08/16/18 - 08/21/18	10/22/18	0.00	3,221.00	0.00	2,432.72	0.00
614	2318285000300	08/17/18 - 08/20/18	10/29/18	0.00	8,958.00	0.00	1,504.08	0.00
615	2318288000270	06/02/18 - 06/12/18	11/05/18	0.00	8,958.00	0.00	0.00	0.00
615	2318291000361	05/03/18 - 05/05/18	11/19/18	0.00	8,958.00	0.00	0.00	0.00
614	5218296000136	09/04/17 - 11/18/17	10/29/18	0.00	7,177.00	0.00	0.00	0.00
614	2318310000371	04/29/18 - 05/02/18	11/19/18	0.00	8,958.00	0.00	1,590.86	0.00
614	5218312000161	06/27/18 - 07/18/18	11/12/18	0.00	8,958.00	0.00	0.00	0.00
615	2019009054581	07/23/18 - 07/31/18	01/14/19	0.00	8,958.00	0.00	0.00	0.00
614	2019031098704	09/30/17 - 10/15/17	02/04/19	0.00	4,479.00	0.00	0.00	0.00
615	2219050009557	06/23/18 - 07/06/18	02/25/19	0.00	7,177.00	0.00	0.00	0.00
614	2219063004210	08/18/18 - 09/18/18	03/11/19	0.00	8,958.00	0.00	0.00	0.00
614	5219063000162	02/03/18 - 04/27/18	03/11/19	0.00	8,958.00	0.00	40,394.95	0.00
614	5219067000187	06/07/18 - 06/16/18	03/18/19	0.00	8,958.00	0.00	0.00	0.00
614	2319079000060	08/18/18 - 09/17/18	04/01/19	0.00	2,428.00	0.00	1,547.49	0.00
614	2319081000282	07/09/18 - 07/19/18	04/15/19	0.00	3,221.00	0.00	0.00	0.00
614	5219095000148	09/15/17 - 10/05/17	04/15/19	0.00	4,479.00	0.00	0.00	0.00
615	5219095000148	09/15/17 - 10/05/17	04/15/19	0.00	8,958.00	0.00	0.00	0.00
614	5219107000177	01/05/18 - 02/07/18	04/22/19	0.00	8,958.00	0.00	0.00	0.00
614	2019121084943	08/06/18 - 08/15/18	05/06/19	0.00	2,698.00	0.00	0.00	0.00
615	2219134009886	04/08/18 - 05/04/18	05/20/19	0.00	4,479.00	0.00	0.00	0.00
615	2019151065298	07/29/18 - 08/10/18	06/10/19	0.00	4,479.00	0.00	0.00	0.00
614	5219155000146	03/25/18 - 06/22/18	06/10/19	0.00	4,479.00	0.00	20,242.10	0.00
615	2019178079194	07/30/18 - 07/31/18	07/01/19	0.00	8,958.00	0.00	0.00	0.00
614	2019184101636	05/04/18 - 05/21/18	07/08/19	0.00	8,958.00	0.00	0.00	0.00
615	5219184000170	03/24/18 - 09/14/18	07/08/19	0.00	2,698.00	0.00	122,966.70	0.00
TOTAL				0.00	414,234.00	0.00	209,143.19	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,106,560.88	ADJUSTMENTS	0.00
COVERED CHARGES	1,085,545.88	CONTRACTUAL ALLOW	440,544.37
NON-COVERD CHARGES	21,015.00	TOTAL MEDICAID LIAB	645,001.51
		LESS: COB	645,001.51
		LESS: COPAYMENT	0.00
		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	103	0	151,494.00	10,216.00
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	103	0	151,494.00	10,216.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	43,001.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	43,001.00	0.00
TOTAL ACCOMODATIONS	110	0	194,495.00	10,216.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,552.72	0.00	OTHER LAB	1,959.00	0.00
MED/SURG SUPPLY	35,436.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	115,878.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,919.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,647.00	714.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,939.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,156.00	0.00	MRI SERVICES	14,354.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	182,775.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,664.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,793.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,185.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,672.00	0.00	INJECTABLE DRUGS	67,982.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	688.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,079.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,652.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	69,910.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,582.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	837.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,965.00	10,085.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,738.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,740.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,355.00	0.00			

TOTAL ANCILLARY	891,050.88	10,799.00
TOTAL ACCOMODATIONS	194,495.00	10,216.00
TOTAL CHARGES	1,085,545.88	21,015.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,149,151.56	ADJUSTMENTS	709,653.52
COVERED CHARGES	20,370,777.13	CONTRACTUAL ALLOW	16,802,103.23
NON-COVERD CHARGES	9,778,374.43	TOTAL MEDICAID LIAB	3,568,673.90
		LESS: COB	12,529.78
		LESS: COPAYMENT	11,022.99
		REIMBURSEMENT	3,545,121.13
		ALL OTHER	2,733,328.18
		FEE SCHEDULE-LAB	759,205.60
		INJECTABLE DRUGS	52,587.35
		TOTAL NUMBER OF CLAIMS	11,430

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,552.33	359,333.23	OTHER LAB	134,164.00	0.00
MED/SURG SUPPLY	624,057.91	481.00	RECREATIONAL THERAPY	75,980.00	0.00
LABORATORY-GENERAL	0.00	1,978.00	EDUCATION & TRAINING	0.00	590.00
RADIOLOGY-DIAGNOSTIC	553,601.36	400,511.00	OTHER THERAPEUTIC SVC	113,970.00	342,600.00
CT SCAN	2,054,812.00	954,783.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	728.00	20,783.28	FEE SCHEDULE LAB	4,515,940.75	833,749.25
EKG/ECG	149,649.00	4,286.00	MRI SERVICES	1,808,000.00	1,166,389.00
IV THERAPY	1,330.00	98.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,990,223.34	1,181,019.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,268.00	8,387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	497,888.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	183,607.00	72,055.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,815,818.00	51,591.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	414,275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	563,190.43	487,836.90
RADIOLOGY THERAPEUTIC	1,089,088.00	740,035.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	9,732.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,070.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	87,419.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	108.00	5,252.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,440.00	IMPL DEV CHARGE PATIENTS	241,928.01	1,549,364.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	122,891.00
OTHER IMAGING SERVICE	802,666.00	546,683.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	200,179.00	4,086.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,707.00	219,887.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	773,156.00	580,313.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,306.00	0.00			
ORGAN ACQUISITION	0.00	9,425.00			
TREATMENT/OBSERV. RM	258,096.00	11,736.00			

TOTAL ANCILLARY	20,370,777.13	9,776,804.43
TOTAL ACCOMODATIONS	0.00	1,570.00
TOTAL CHARGES	20,370,777.13	9,778,374.43

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 09/01/17 THROUGH 08/31/18
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	2017281002714	10/03/17 - 10/03/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
8623	5917303000663	09/14/17 - 09/14/17	11/06/17	0.00	71.00	0.00	0.00	0.00
615	2017310037619	10/29/17 - 10/29/17	11/13/17	0.00	4,479.00	0.00	0.00	0.00
615	2017310037619	10/29/17 - 10/29/17	11/13/17	0.00	4,479.00	0.00	0.00	0.00
615	2017321068511	11/11/17 - 11/11/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017323001423	11/10/17 - 11/10/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017323001423	11/10/17 - 11/10/17	11/27/17	0.00	4,479.00	0.00	0.00	0.00
615	2017332079783	11/18/17 - 11/18/17	12/04/17	0.00	2,698.00	0.00	0.00	0.00
615	2017332079783	11/18/17 - 11/18/17	12/04/17	0.00	2,698.00	0.00	0.00	0.00
615	2017357032380	12/13/17 - 12/13/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	5918011001344	11/28/17 - 11/28/17	01/15/18	0.00	2,698.00	0.00	0.00	0.00
615	5918011001344	11/28/17 - 11/28/17	01/15/18	0.00	2,698.00	0.00	0.00	0.00
615	2018029029960	01/22/18 - 01/22/18	02/05/18	0.00	4,479.00	0.00	0.00	0.00
615	2018047074189	11/27/17 - 11/27/17	02/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018047074189	11/27/17 - 11/27/17	02/26/18	0.00	4,479.00	0.00	0.00	0.00
615	2018115068053	04/19/18 - 04/19/18	04/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018123094908	04/27/18 - 04/27/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018123094908	04/27/18 - 04/27/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018124085873	04/23/18 - 04/23/18	05/14/18	0.00	4,479.00	0.00	0.00	0.00
615	2018136070429	05/11/18 - 05/11/18	05/21/18	0.00	4,479.00	0.00	0.00	0.00
615	2018144094059	05/14/18 - 05/14/18	05/28/18	0.00	4,479.00	0.00	0.00	0.00
615	2018156075183	05/29/18 - 05/29/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018156075184	05/29/18 - 05/29/18	06/11/18	0.00	4,479.00	0.00	0.00	0.00
615	2018164078721	05/31/18 - 05/31/18	06/18/18	0.00	2,698.00	0.00	0.00	0.00
615	2018164078721	05/31/18 - 05/31/18	06/18/18	0.00	2,698.00	0.00	0.00	0.00
615	2018180061978	06/22/18 - 06/22/18	07/09/18	0.00	2,698.00	0.00	0.00	0.00
615	2018186098296	06/27/18 - 06/27/18	07/09/18	0.00	4,479.00	0.00	0.00	0.00
615	5918199001143	06/14/18 - 06/14/18	07/23/18	0.00	4,479.00	0.00	0.00	0.00
615	5918199001143	06/14/18 - 06/14/18	07/23/18	0.00	4,479.00	0.00	0.00	0.00
615	2018219070902	07/31/18 - 07/31/18	08/13/18	0.00	4,479.00	0.00	0.00	0.00
615	2018219070902	07/31/18 - 07/31/18	08/13/18	0.00	4,479.00	0.00	0.00	0.00
615	2218222013533	07/13/18 - 07/13/18	08/13/18	0.00	2,698.00	0.00	0.00	0.00
TOTAL				0.00	122,891.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	861,905.38	ADJUSTMENTS	0.00
COVERED CHARGES	330,280.56	CONTRACTUAL ALLOW	-51,541.03
NON-COVERD CHARGES	531,624.82	TOTAL MEDICAID LIAB	381,821.59
		LESS: COB	381,611.12
		LESS: COPAYMENT	210.47
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 117

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
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,592.36	10,012.13	OTHER LAB	1,872.00	0.00
MED/SURG SUPPLY	17,288.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,070.08	3,190.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,741.00	35,245.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	49,402.00	10,621.00
EKG/ECG	2,772.00	154.00	MRI SERVICES	8,958.00	87,799.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,325.00	75,929.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,478.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,074.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,720.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,979.00	217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,561.12	13,548.94
RADIOLOGY THERAPEUTIC	37,132.00	51,030.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,978.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	175.00	140,856.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,833.00
OTHER IMAGING SERVICE	2,614.00	26,778.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,809.00	2,884.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,147.00	46,956.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	741.00	0.00			
ORGAN ACQUISITION	0.00	1,243.75			
TREATMENT/OBSERV. RM	7,650.00	2,350.00			

TOTAL ANCILLARY	330,280.56	531,624.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	330,280.56	531,624.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/17 THROUGH 08/31/18
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	2018095101904	03/17/18 - 03/17/18	04/09/18	0.00	2,698.00	0.00	1,182.66	0.00
615	2018095101904	03/17/18 - 03/17/18	04/09/18	0.00	4,479.00	0.00	1,182.66	0.00
615	2018176022878	06/06/18 - 06/06/18	07/02/18	0.00	2,698.00	0.00	3,905.02	0.00
615	2018176022878	06/06/18 - 06/06/18	07/02/18	0.00	4,479.00	0.00	3,905.02	0.00
615	2019022072538	06/21/18 - 06/21/18	01/28/19	0.00	4,479.00	0.00	625.41	0.00
TOTAL				0.00	18,833.00	0.00	10,800.77	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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,180.68	ADJUSTMENTS	892.63
COVERED CHARGES	104,831.42	CONTRACTUAL ALLOW	100,098.87
NON-COVERD CHARGES	13,349.26	TOTAL MEDICAID LIAB	4,732.55
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	4,537.55
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.50	2.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,171.16	819.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,564.00	9,376.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,627.00	478.00
EKG/ECG	1,848.00	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	377.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,103.00	1,895.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,542.76	778.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,087.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	975.00	0.00			

TOTAL ANCILLARY	104,831.42	13,349.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	104,831.42	13,349.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,337.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,337.00	CONTRACTUAL ALLOW	499.77
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	837.23
		LESS: COB	831.23
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	1,337.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,337.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,337.00	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,597,076.97	ADJUSTMENTS	122,467.11
COVERED CHARGES	1,452,665.95	CONTRACTUAL ALLOW	1,272,037.95
NON-COVERD CHARGES	144,411.02	TOTAL MEDICAID LIAB	180,628.00
		LESS: COB	0.00
		LESS: COPAYMENT	152.89
		REIMBURSEMENT	180,475.11
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,975.00	1,502.73	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,471.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163,187.00	25,412.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,737.00	6,384.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,658.00	3,381.00
EKG/ECG	154.00	154.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	367,326.00	56,531.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,963.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	220,786.09	5,528.29
RADIOLOGY THERAPEUTIC	116,305.00	5,420.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,978.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	278,062.00	19,457.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	310.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,546.00	7,144.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,496.00	9,519.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,452,665.95	144,411.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,452,665.95	144,411.02

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,734,124.67	ADJUSTMENTS	0.00
COVERED CHARGES	4,743,505.67	CONTRACTUAL ALLOW	1,435,538.28
NON-COVERD CHARGES	1,990,619.00	TOTAL MEDICAID LIAB	3,307,967.39
		LESS: COB	2,230.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,305,736.44

TOTAL NUMBER OF ADMISSIONS 320

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,367	0	3,697,254.00	1,990,619.00
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	2,367	0	3,697,254.00	1,990,619.00
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	2,367	0	3,697,254.00	1,990,619.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,529.44	0.00	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	1,390.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	541,134.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,406.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,468.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,464.00	0.00	MRI SERVICES	4,479.00	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	32,454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335,763.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,923.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	33,294.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,788.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,223.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,046,251.67	0.00
TOTAL ACCOMODATIONS	3,697,254.00	1,990,619.00
TOTAL CHARGES	4,743,505.67	1,990,619.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	150,683,852.53	ADJUSTMENTS	8,116,979.58
COVERED CHARGES	148,076,178.49	CONTRACTUAL ALLOW	111,098,519.27
NON-COVERD CHARGES	2,607,674.04	TOTAL MEDICAID LIAB	36,977,659.22
		LESS: COB	280,283.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,697,376.20

TOTAL NUMBER OF ADMISSIONS 2,434

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,746	0	8,470,172.00	1,210,477.00
ROUTINE NURSERY	676	0	824,223.00	265,475.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	36.00
TOTAL ROUTINE	11,422	0	9,294,395.00	1,475,988.00
SPECIAL CARE SERVICES				
CCU	216	0	381,328.00	0.00
ICU	2,600	0	5,369,640.00	21,740.00
NICU	907	0	3,525,509.00	0.00
PED ICU	864	0	3,242,772.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	320	0	1,097,920.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,907	0	13,617,169.00	21,740.00
TOTAL ACCOMODATIONS	16,329	0	22,911,564.00	1,497,728.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,683,652.77	81,622.61	OTHER LAB	631,510.00	23,117.00
MED/SURG SUPPLY	13,151,423.00	81,484.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,078,303.64	171,432.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,836,872.00	8,052.00	OTHER THERAPEUTIC SVC	0.00	2,432.00
CT SCAN	3,608,590.00	73,795.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	868,198.02	4,991.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	279,176.00	0.00	MRI SERVICES	1,251,983.00	4,237.00
IV THERAPY	446,617.00	6,998.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,911,470.00	57,913.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	366,945.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,528,702.00	38,860.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,878,404.00	12,868.00	AMBULANCE	0.00	0.00
GI SERVICES	395,431.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,652,085.00	799.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	663,055.00	4,080.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	867,348.98	656.00	INJECTABLE DRUGS	8,678,562.26	45,764.41
RADIOLOGY THERAPEUTIC	127,919.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	491,698.45	3,618.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	363,135.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	302,029.00	76,030.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	344.00	77,380.00	TRAUMA RESPONSE	0.00	209,281.00
PSYCHIATRIC SERVICES	45,925.00	0.00	IMPL DEV CHARGE PATIENTS	9,271,662.00	9,830.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	466,196.00	31,689.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,680,240.00	34,186.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,718.00	4,271.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,969,281.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,030,759.00	44,560.00			
ORGAN ACQUISITION	249,922.00	0.00			
TREATMENT/OBSERV. RM	279,457.00	0.00			

TOTAL ANCILLARY	125,164,614.49	1,109,946.04
TOTAL ACCOMODATIONS	22,911,564.00	1,497,728.00
TOTAL CHARGES	148,076,178.49	2,607,674.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,167,893.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,144,166.37	CONTRACTUAL ALLOW	1,389,052.23
NON-COVERD CHARGES	23,726.83	TOTAL MEDICAID LIAB	755,114.14
		LESS: COB	755,114.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 34

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	99	0	78,408.00	14,339.00
ROUTINE NURSERY	2	0	990.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	101	0	79,398.00	14,339.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	15	0	25,750.00	0.00
NICU	0	0	0.00	0.00
PED ICU	37	0	143,135.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	6	0	20,586.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	189,471.00	0.00
TOTAL ACCOMODATIONS	159	0	268,869.00	14,339.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351,404.62	0.00	OTHER LAB	6,659.00	0.00
MED/SURG SUPPLY	231,655.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	155,673.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,567.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,316.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,264.00	0.00	MRI SERVICES	23,056.00	0.00
IV THERAPY	6,830.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,889.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,993.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	185,954.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,739.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,338.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,468.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	18,395.00	0.00	INJECTABLE DRUGS	21,678.20	2,492.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,277.08	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,667.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,030.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,403.00	TRAUMA RESPONSE	0.00	4,492.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	412,564.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,685.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,782.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,961.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	89,230.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	502.00	0.00			

TOTAL ANCILLARY	1,875,297.37	9,387.83
TOTAL ACCOMODATIONS	268,869.00	14,339.00
TOTAL CHARGES	2,144,166.37	23,726.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,908,899.00	ADJUSTMENTS	3,983,721.29
COVERED CHARGES	58,994,159.64	CONTRACTUAL ALLOW	47,900,894.35
NON-COVERD CHARGES	5,914,739.36	TOTAL MEDICAID LIAB	11,093,265.29
		LESS: COB	38,525.97
		LESS: COPAYMENT	51,978.87
		REIMBURSEMENT	11,002,760.45
		ALL OTHER	8,684,604.74
		FEE SCHEDULE-LAB	825,878.69
		INJECTABLE DRUGS	1,492,277.02

TOTAL NUMBER OF CLAIMS 32,682

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,929,784.35	8,969.19	OTHER LAB	859,820.00	32,158.00
MED/SURG SUPPLY	1,859,485.00	1,796.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	415.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,805,449.00	62,743.00	OTHER THERAPEUTIC SVC	0.00	12,249.00
CT SCAN	2,979,860.00	611,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	107,465.00	49,709.02	FEE SCHEDULE LAB	8,841,167.90	192,180.15
EKG/ECG	214,746.00	2,212.00	MRI SERVICES	2,183,284.00	453,347.00
IV THERAPY	1,008,039.00	52,877.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,653,736.24	667,987.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	508.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	801,327.00	17,862.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,651,132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	483,778.14	206,695.81	CAST ROOM	11,694.00	1,449.00
EMERGENCY ROOM	4,914,614.00	18,160.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,102,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,761,639.81	1,352,437.90
RADIOLOGY THERAPEUTIC	2,927,570.00	74,202.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,198.00	32,478.45	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,827.00	16,890.58	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	25,766.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,086,702.70	526,534.00	TRAUMA RESPONSE	0.00	202,334.00
PSYCHIATRIC SERVICES	76,567.00	29,811.00	IMPL DEV CHARGE PATIENTS	734,509.00	260,458.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	327.00
OTHER IMAGING SERVICE	1,078,504.00	312,539.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	698,697.00	29,290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	488,623.00	99,900.70			
AUDIOLOGY	6,860.00	3,346.00			
CARDIOLOGY	874,745.50	508,357.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	240.00			
E E G	817,974.00	8,321.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	945,473.00	38,899.00			

TOTAL ANCILLARY	58,994,159.64	5,914,739.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,994,159.64	5,914,739.36

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
518	5918065001508	12/06/17 - 12/06/17	03/12/18	0.00	327.00	0.00	0.00	0.00
TOTAL				0.00	327.00	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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,881,642.51	ADJUSTMENTS	0.00
COVERED CHARGES	1,046,654.51	CONTRACTUAL ALLOW	489,703.22
NON-COVERD CHARGES	834,988.00	TOTAL MEDICAID LIAB	556,951.29
		LESS: COB	556,363.29
		LESS: COPAYMENT	588.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 645

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,742.34	2,006.72	OTHER LAB	22,583.00	1,392.00
MED/SURG SUPPLY	61,807.00	2,082.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,406.00	19,336.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,984.00	67,973.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	662.02	FEE SCHEDULE LAB	164,889.80	4,387.00
EKG/ECG	5,730.00	0.00	MRI SERVICES	9,220.00	49,508.00
IV THERAPY	23,946.00	2,968.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,051.06	93,315.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,210.00	304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	78,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,598.00	CAST ROOM	455.00	688.00
EMERGENCY ROOM	114,255.00	5,435.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,237.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,107.81	363,122.82
RADIOLOGY THERAPEUTIC	60,451.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,060.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	991.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,916.00	13,118.00	TRAUMA RESPONSE	0.00	4,492.00
PSYCHIATRIC SERVICES	0.00	182.00	IMPL DEV CHARGE PATIENTS	5,059.00	107,728.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,849.00	40,019.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,272.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,247.00	6,798.00			
AUDIOLOGY	1,372.00	0.00			
CARDIOLOGY	34,347.50	34,299.50			
AMBULATORY SURGERY	328.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,043.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,762.00	8,522.00			

TOTAL ANCILLARY	1,046,654.51	834,988.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,046,654.51	834,988.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,015,795.51	ADJUSTMENTS	10,888.00
COVERED CHARGES	2,797,221.88	CONTRACTUAL ALLOW	2,695,621.88
NON-COVERD CHARGES	218,573.63	TOTAL MEDICAID LIAB	101,600.00
		LESS: COB	60.44
		LESS: COPAYMENT	3,576.00
		REIMBURSEMENT	97,963.56
		TOTAL NUMBER OF CLAIMS	2,032

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,754.77	0.00	OTHER LAB	21,787.00	37.00
MED/SURG SUPPLY	19,874.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	156,080.00	16,043.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	288,075.00	45,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	361.00	FEE SCHEDULE LAB	412,955.75	11,342.00
EKG/ECG	22,278.00	0.00	MRI SERVICES	31,678.00	24,790.00
IV THERAPY	106,837.00	6,867.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,025.34	23,472.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,342.00	1,828.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,533,451.00	2,366.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,896.36	41,336.61
RADIOLOGY THERAPEUTIC	3,127.00	829.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	325.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,835.00	1,682.00	TRAUMA RESPONSE	0.00	20,175.00
PSYCHIATRIC SERVICES	0.00	479.00	IMPL DEV CHARGE PATIENTS	446.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,524.00	19,185.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,049.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	140.00			
CARDIOLOGY	666.00	1,332.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,199.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,717.66	0.00			

TOTAL ANCILLARY	2,797,221.88	218,573.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,797,221.88	218,573.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,799.12	ADJUSTMENTS	0.00
COVERED CHARGES	61,483.12	CONTRACTUAL ALLOW	38,396.75
NON-COVERD CHARGES	3,316.00	TOTAL MEDICAID LIAB	23,086.37
		LESS: COB	23,047.37
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,015.12	0.00	OTHER LAB	1,566.00	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	2,571.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,889.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,729.00	78.00
EKG/ECG	316.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,013.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	37,277.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	996.00	1,349.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	61,483.12	3,316.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	61,483.12	3,316.00

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,000,354.81	ADJUSTMENTS	648,720.34
COVERED CHARGES	12,525,096.06	CONTRACTUAL ALLOW	11,105,113.41
NON-COVERD CHARGES	475,258.75	TOTAL MEDICAID LIAB	1,419,982.65
		LESS: COB	4,456.16
		LESS: COPAYMENT	765.00
		REIMBURSEMENT	1,414,761.49
		TOTAL NUMBER OF CLAIMS	239

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,442.52	1,392.00	OTHER LAB	2,330.00	14,305.00
MED/SURG SUPPLY	563,696.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,056.00	28,814.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,018.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,786.00	FEE SCHEDULE LAB	120,643.00	392.00
EKG/ECG	316.00	316.00	MRI SERVICES	0.00	9,364.00
IV THERAPY	34,414.00	1,543.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	878,516.32	170,344.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,212.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,279.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,608.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,626.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,293,277.98	45,105.06
RADIOLOGY THERAPEUTIC	343,972.00	16,440.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,663.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	991.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,785.00	3,977.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,974,119.00	24,022.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,154.00	878.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,924.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,172.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,446,565.24	144,559.76			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,970.00	3,366.00			

TOTAL ANCILLARY	12,525,096.06	475,258.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,525,096.06	475,258.75

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

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	414,101.10	ADJUSTMENTS	0.00
COVERED CHARGES	178,863.10	CONTRACTUAL ALLOW	9,023.48
NON-COVERD CHARGES	235,238.00	TOTAL MEDICAID LIAB	169,839.62
		LESS: COB	169,836.62
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

AU MEDICAL CENTER, INC
1120 15TH ST
AUGUSTA,GA 30912-0004

PROVIDER NUMBER
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,100.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,226.00	34.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	706.00	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	158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,154.00	32,154.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,960.00	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	169.00	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	133,192.00	115,906.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	86,952.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	198.00	192.00			

TOTAL ANCILLARY	178,863.10	235,238.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	178,863.10	235,238.00

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,066,890.00	ADJUSTMENTS	3,915.21
COVERED CHARGES	976,517.00	CONTRACTUAL ALLOW	635,442.56
NON-COVERD CHARGES	90,373.00	TOTAL MEDICAID LIAB	341,074.44
		LESS: COB	4,280.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	336,794.02

TOTAL NUMBER OF ADMISSIONS 55

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	211	0	179,777.00	53,471.00
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	179,777.00	53,471.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	25	0	39,375.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	25	0	39,375.00	0.00
TOTAL ACCOMODATIONS	236	0	219,152.00	53,471.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132,236.00	0.00	OTHER LAB	2,007.00	0.00
MED/SURG SUPPLY	70,355.00	15.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	268,433.00	0.00	EDUCATION & TRAINING	1,200.00	0.00
RADIOLOGY-DIAGNOSTIC	18,140.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	100,535.00	6,022.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,898.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,223.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,368.00	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	30,804.00	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	358.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,144.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,166.00	12,970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,604.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,845.00	15,672.00			

TOTAL ANCILLARY	757,365.00	36,902.00
TOTAL ACCOMODATIONS	219,152.00	53,471.00
TOTAL CHARGES	976,517.00	90,373.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,352,497.00	ADJUSTMENTS	22,166.82
COVERED CHARGES	1,228,459.00	CONTRACTUAL ALLOW	993,483.13
NON-COVERD CHARGES	124,038.00	TOTAL MEDICAID LIAB	234,975.87
		LESS: COB	203.25
		LESS: COPAYMENT	1,158.00
		REIMBURSEMENT	233,614.62
		ALL OTHER	220,928.11
		FEE SCHEDULE-LAB	11,205.94
		INJECTABLE DRUGS	1,480.57

TOTAL NUMBER OF CLAIMS 773

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,884.00	24.00	OTHER LAB	9,061.00	0.00
MED/SURG SUPPLY	43,333.00	90.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.00	EDUCATION & TRAINING	0.00	100.00
RADIOLOGY-DIAGNOSTIC	66,632.00	2,620.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,180.00	44,066.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,845.00	7,030.00	FEE SCHEDULE LAB	201,512.00	25,588.00
EKG/ECG	14,818.00	1,434.00	MRI SERVICES	58,155.00	0.00
IV THERAPY	0.00	47.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,707.00	782.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,106.00	1,512.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,436.00	17,264.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	282,976.00	7,631.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,299.00	1,768.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	494.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	154.00
OTHER IMAGING SERVICE	25,465.00	2,861.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,076.00	3,376.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,661.00	2,151.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,219.00	5,426.00			

TOTAL ANCILLARY	1,228,459.00	124,038.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,228,459.00	124,038.00

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 10/01/17 THROUGH 09/30/18
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
6369	2218201016761	03/11/18 - 03/11/18	07/23/18	0.00	40.00	0.00	0.00	0.00
30	2218255012280	09/06/18 - 09/06/18	09/17/18	0.00	114.00	0.00	0.00	0.00
TOTAL				0.00	154.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,621.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,359.00	CONTRACTUAL ALLOW	3,108.19
NON-COVERD CHARGES	262.00	TOTAL MEDICAID LIAB	3,250.81
		LESS: COB	3,250.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	281.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	296.00	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	1,439.00	262.00
EKG/ECG	239.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,784.00	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	320.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,359.00	262.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,359.00	262.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	191,346.00	ADJUSTMENTS	2,687.20
COVERED CHARGES	177,970.00	CONTRACTUAL ALLOW	167,788.76
NON-COVERD CHARGES	13,376.00	TOTAL MEDICAID LIAB	10,181.24
		LESS: COB	41.01
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	9,870.23
		TOTAL NUMBER OF CLAIMS	166

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,999.00	32.00	OTHER LAB	669.00	0.00
MED/SURG SUPPLY	2,580.00	24.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,095.00	7,352.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,989.00	2,701.00
EKG/ECG	717.00	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	532.00	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	111,755.00	592.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,069.00	148.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,022.00	2,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,970.00	13,376.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,970.00	13,376.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	898.00	ADJUSTMENTS	0.00
COVERED CHARGES	898.00	CONTRACTUAL ALLOW	621.58
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	276.42
		LESS: COB	276.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.00	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	239.00	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	643.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	898.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	898.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,629,815.62	ADJUSTMENTS	2,604,496.05
COVERED CHARGES	67,295,948.78	CONTRACTUAL ALLOW	51,192,141.23
NON-COVERD CHARGES	2,333,866.84	TOTAL MEDICAID LIAB	16,103,807.55
		LESS: COB	100,165.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,003,641.72

TOTAL NUMBER OF ADMISSIONS 1,924

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,115	0	3,796,100.00	890,285.00
ROUTINE NURSERY	913	0	797,350.00	14,058.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,028	0	4,593,450.00	904,343.00
SPECIAL CARE SERVICES				
CCU	990	0	816,750.00	0.00
ICU	1,775	0	2,302,885.00	8,250.00
NICU	326	0	701,552.00	0.00
PED ICU	11	0	13,310.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,102	0	3,834,497.00	8,250.00
TOTAL ACCOMODATIONS	11,130	0	8,427,947.00	912,593.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,802,861.25	68,959.37	OTHER LAB	394,671.00	0.00
MED/SURG SUPPLY	5,102,839.62	121,458.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,093,074.31	147,072.23	EDUCATION & TRAINING	1,650.00	0.00
RADIOLOGY-DIAGNOSTIC	936,489.00	5,911.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,007,294.00	23,184.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,878.00	2,270.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,236,669.00	6,076.44	MRI SERVICES	552,472.00	8,012.00
IV THERAPY	489,014.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,108,670.75	56,274.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,048,419.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,471,501.00	74,609.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	889,040.00	3,297.40	AMBULANCE	0.00	375.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,468,023.00	24,389.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	594,628.00	1,896.00	DRUG-SPECIFIC/HOME IV	0.00	81,550.00
LABORATORY PATHOLOGIC	165,122.00	730.00	INJECTABLE DRUGS	4,450,417.50	441,002.00
RADIOLOGY THERAPEUTIC	126.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,987.00	76.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,101.00	1,216.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	331,328.00	45,238.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,542.00	10,392.00	TRAUMA RESPONSE	0.00	56,339.00
PSYCHIATRIC SERVICES	4,950.00	0.00	IMPL DEV CHARGE PATIENTS	2,512,605.25	2,131.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	170,874.00	49,172.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	223,590.00	119,649.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	256,007.00	56,060.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,196,912.10	3,430.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,865.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,381.00	10,505.00			

TOTAL ANCILLARY	58,868,001.78	1,421,273.84
TOTAL ACCOMODATIONS	8,427,947.00	912,593.00
TOTAL CHARGES	67,295,948.78	2,333,866.84

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	463,985.65	ADJUSTMENTS	0.00
COVERED CHARGES	460,214.65	CONTRACTUAL ALLOW	201,489.03
NON-COVERD CHARGES	3,771.00	TOTAL MEDICAID LIAB	258,725.62
		LESS: COB	258,725.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	27,500.00	2,475.00
ROUTINE NURSERY	17	0	21,950.00	781.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	49,450.00	3,256.00
SPECIAL CARE SERVICES				
CCU	1	0	825.00	0.00
ICU	4	0	5,775.00	0.00
NICU	5	0	10,760.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	17,360.00	0.00
TOTAL ACCOMODATIONS	77	0	66,810.00	3,256.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,289.25	0.00	OTHER LAB	7,920.00	0.00
MED/SURG SUPPLY	39,138.65	515.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,036.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	380.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,313.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,799.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,949.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,580.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	659.00	0.00	INJECTABLE DRUGS	3,751.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	456.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	304.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	147.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,169.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	624.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,615.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,927.00	0.00			

TOTAL ANCILLARY	393,404.65	515.00
TOTAL ACCOMODATIONS	66,810.00	3,256.00
TOTAL CHARGES	460,214.65	3,771.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,706,149.53	ADJUSTMENTS	1,588,049.34
COVERED CHARGES	46,082,605.25	CONTRACTUAL ALLOW	39,552,744.50
NON-COVERD CHARGES	2,623,544.28	TOTAL MEDICAID LIAB	6,529,860.75
		LESS: COB	7,015.68
		LESS: COPAYMENT	15,516.69
		REIMBURSEMENT	6,507,328.38
		ALL OTHER	5,905,478.83
		FEE SCHEDULE-LAB	550,548.38
		INJECTABLE DRUGS	51,301.17
		TOTAL NUMBER OF CLAIMS	12,488

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,899,857.15	4,029.00	OTHER LAB	211,280.00	958.00
MED/SURG SUPPLY	2,016,172.64	26,875.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	6,775.00	51,000.00
RADIOLOGY-DIAGNOSTIC	1,448,393.00	24,985.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,287,875.00	105,090.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	165,456.00	30,159.03	FEE SCHEDULE LAB	8,144,810.96	280,877.00
EKG/ECG	883,798.00	5,856.00	MRI SERVICES	708,331.00	41,364.00
IV THERAPY	3,053,388.00	375,750.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,170,139.00	314,277.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	103,549.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	167,445.00	459,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	677,985.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,681,948.00	385,191.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	639,566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	23,940.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,663.75	6,694.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,672.00	2,673.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,596.00	2,660.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	92,381.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	426,815.00	26,908.00	TRAUMA RESPONSE	0.00	6,477.00
PSYCHIATRIC SERVICES	155,100.00	9,075.00	IMPL DEV CHARGE PATIENTS	299,822.75	0.00
LITHOTRIPSY	142,328.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	382,164.00	30,223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	130,226.00	46,371.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	582,935.00	55,536.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	803,679.00	172,219.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	291,780.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,287,055.00	42,333.00			

TOTAL ANCILLARY	46,082,605.25	2,623,544.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,082,605.25	2,623,544.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	818,109.75	ADJUSTMENTS	0.00
COVERED CHARGES	663,195.75	CONTRACTUAL ALLOW	265,963.02
NON-COVERD CHARGES	154,914.00	TOTAL MEDICAID LIAB	397,232.73
		LESS: COB	397,144.03
		LESS: COPAYMENT	88.70
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	140

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,735.00	0.00	OTHER LAB	6,471.00	0.00
MED/SURG SUPPLY	48,601.75	617.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,841.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,501.00	35,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,672.00	FEE SCHEDULE LAB	121,943.00	3,301.00
EKG/ECG	4,406.00	0.00	MRI SERVICES	8,014.00	0.00
IV THERAPY	33,870.00	1,309.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,683.00	83,935.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,871.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	686.00	4,594.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	158,866.00	6,499.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,844.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,904.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	152.00	1,444.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,877.00	3,136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,097.00	0.00
LITHOTRIPSY	17,791.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,127.00	11,060.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,205.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,140.00	1,247.00			

TOTAL ANCILLARY	663,195.75	154,914.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	663,195.75	154,914.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,029,018.00	ADJUSTMENTS	1,783.02
COVERED CHARGES	997,603.00	CONTRACTUAL ALLOW	977,632.42
NON-COVERD CHARGES	31,415.00	TOTAL MEDICAID LIAB	19,970.58
		LESS: COB	0.00
		LESS: COPAYMENT	675.00
		REIMBURSEMENT	19,295.58

TOTAL NUMBER OF CLAIMS 357

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,416.50	0.00	OTHER LAB	719.00	0.00
MED/SURG SUPPLY	28,003.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,533.00	2,034.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,594.00	2,024.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	182,725.00	5,632.00
EKG/ECG	6,066.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,566.00	3,366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	205.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	564,402.00	17,039.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,979.50	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	936.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,140.00	1,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	997,603.00	31,415.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	997,603.00	31,415.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,794.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,764.50	CONTRACTUAL ALLOW	21,466.83
NON-COVERD CHARGES	1,030.00	TOTAL MEDICAID LIAB	8,297.67
		LESS: COB	8,288.67
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	448.75	0.00	OTHER LAB	800.00	0.00
MED/SURG SUPPLY	682.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,191.00	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	8,251.00	245.00
EKG/ECG	674.00	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	15,914.00	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	363.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	440.00	785.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,764.50	1,030.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,764.50	1,030.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,077,491.05	ADJUSTMENTS	218,509.28
COVERED CHARGES	6,748,117.05	CONTRACTUAL ALLOW	6,074,970.80
NON-COVERD CHARGES	329,374.00	TOTAL MEDICAID LIAB	673,146.25
		LESS: COB	26,248.34
		LESS: COPAYMENT	573.00
		REIMBURSEMENT	646,324.91

TOTAL NUMBER OF CLAIMS 114

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,679,110.05	0.00	OTHER LAB	46,915.00	0.00
MED/SURG SUPPLY	350,271.75	627.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	430.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,543.00	6,764.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,487.00	20,548.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	227,780.00	9,173.00
EKG/ECG	41,294.00	5,055.00	MRI SERVICES	986.00	1,725.00
IV THERAPY	465,511.00	46,218.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,348,209.00	101,960.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,290.00	43,108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	174,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,096.00	3,493.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,373.75	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	3,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	924.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,508,815.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,845.00	875.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,114.00	2,609.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,586.00	6,504.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	391,493.00	55,998.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	739.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	127,710.00	21,287.00			

TOTAL ANCILLARY	6,748,117.05	329,374.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,748,117.05	329,374.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,918,774.96	ADJUSTMENTS	3,150,887.26
COVERED CHARGES	45,299,940.31	CONTRACTUAL ALLOW	36,059,547.08
NON-COVERD CHARGES	2,618,834.65	TOTAL MEDICAID LIAB	9,240,393.23
		LESS: COB	93,460.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,146,932.68

TOTAL NUMBER OF ADMISSIONS 946

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,626	0	4,290,635.00	959,648.00
ROUTINE NURSERY	1,358	0	2,543,730.00	860,225.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,984	0	6,834,365.00	1,819,873.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	664	0	2,703,412.00	0.00
NICU	216	0	1,418,450.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	880	0	4,121,862.00	0.00
TOTAL ACCOMODATIONS	5,864	0	10,956,227.00	1,819,873.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,734,879.54	173,280.15	OTHER LAB	110,584.00	0.00
MED/SURG SUPPLY	1,500,436.40	27,221.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,837,940.68	100,978.00	EDUCATION & TRAINING	2,860.00	257.00
RADIOLOGY-DIAGNOSTIC	622,528.00	2,828.00	OTHER THERAPEUTIC SVC	0.00	11,328.00
CT SCAN	1,257,502.00	16,512.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	367,633.00	10,284.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	165,212.00	736.00	MRI SERVICES	457,257.50	4,291.00
IV THERAPY	39,857.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,717,530.00	19,567.00	DURABLE MED. EQUIP.	0.00	818.00
LABOR/DELIVERY ROOM	1,061,154.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,285,535.77	48,217.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	505,644.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,616.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	825,317.00	2,205.00	SPECIAL SERVICES	0.00	99,595.00
RECOVERY ROOM	301,753.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	65,704.50
LABORATORY PATHOLOGIC	310,310.00	0.00	INJECTABLE DRUGS	6,840,990.50	53,412.00
RADIOLOGY THERAPEUTIC	351,186.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	335,858.00	15,252.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	156,589.00	3,306.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	340,797.00	2,319.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.00	1,158.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,067,330.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	261,840.50	67,917.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	450,304.50	54,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,609.00	10,918.00			
AUDIOLOGY	113,098.00	0.00			
CARDIOLOGY	1,138,243.50	4,146.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,932.00	1,798.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,259.00	0.00			

TOTAL ANCILLARY	34,343,713.31	798,961.65
TOTAL ACCOMODATIONS	10,956,227.00	1,819,873.00
TOTAL CHARGES	45,299,940.31	2,618,834.65

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,228,080.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,152,667.50	CONTRACTUAL ALLOW	548,823.43
NON-COVERD CHARGES	75,413.00	TOTAL MEDICAID LIAB	603,844.07
		LESS: COB	603,844.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	70	0	86,909.00	5,175.00
ROUTINE NURSERY	55	0	128,594.00	55,434.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	125	0	215,503.00	60,609.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	45	0	175,533.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	45	0	175,533.00	0.00
TOTAL ACCOMODATIONS	170	0	391,036.00	60,609.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,422.00	0.00	OTHER LAB	2,790.00	0.00
MED/SURG SUPPLY	43,828.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	143,176.00	0.00	EDUCATION & TRAINING	166.00	0.00
RADIOLOGY-DIAGNOSTIC	11,533.00	0.00	OTHER THERAPEUTIC SVC	0.00	708.00
CT SCAN	15,202.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,789.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,048.00	0.00	MRI SERVICES	5,276.00	0.00
IV THERAPY	531.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,726.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	73,842.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,847.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,096.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,640.00	0.00	SPECIAL SERVICES	0.00	6,735.00
RECOVERY ROOM	17,641.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,757.00	0.00	INJECTABLE DRUGS	86,026.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,660.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,007.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,438.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,582.00	7,361.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,633.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,885.00	0.00			
CARDIOLOGY	21,090.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	761,631.50	14,804.00
TOTAL ACCOMODATIONS	391,036.00	60,609.00
TOTAL CHARGES	1,152,667.50	75,413.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,678,972.64	ADJUSTMENTS	604,987.28
COVERED CHARGES	14,325,651.54	CONTRACTUAL ALLOW	12,395,619.69
NON-COVERD CHARGES	1,353,321.10	TOTAL MEDICAID LIAB	1,930,031.85
		LESS: COB	6,777.13
		LESS: COPAYMENT	5,221.21
		REIMBURSEMENT	1,918,033.51
		ALL OTHER	1,662,839.70
		FEE SCHEDULE-LAB	110,227.57
		INJECTABLE DRUGS	144,966.24

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,716.50	6,053.00	OTHER LAB	264,928.00	0.00
MED/SURG SUPPLY	337,002.00	5,121.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	244.80	EDUCATION & TRAINING	2,151.00	0.00
RADIOLOGY-DIAGNOSTIC	457,653.00	5,096.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,504,060.00	59,921.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,668.00	28,086.00	FEE SCHEDULE LAB	1,683,335.21	68,955.80
EKG/ECG	97,960.00	1,104.00	MRI SERVICES	1,248,395.00	55,045.00
IV THERAPY	206,658.00	16,940.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,440,955.00	140,938.00	DURABLE MED. EQUIP.	0.00	4,457.00
LABOR/DELIVERY ROOM	23,797.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,387.00	4,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	403,643.00	1,324.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343,881.00	51,971.00	SPECIAL SERVICES	0.00	774.00
RECOVERY ROOM	297,227.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	54,787.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,539,968.00	465,561.50
RADIOLOGY THERAPEUTIC	542,279.00	9,876.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,019.00	7,110.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,428.00	4,273.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	193,362.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,252.00	1,570.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,320.00	1,760.00	IMPL DEV CHARGE PATIENTS	153,169.99	2,415.00
LITHOTRIPSY	23,352.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537,157.00	75,677.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,675.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,767.00	12,215.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	198,833.00	27,710.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,191.00	0.00			
ORGAN ACQUISITION	0.00	37,352.00			
TREATMENT/OBSERV. RM	143,951.84	9,549.00			

TOTAL ANCILLARY	14,325,651.54	1,353,321.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,325,651.54	1,353,321.10

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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	575,909.82	ADJUSTMENTS	0.00
COVERED CHARGES	425,242.52	CONTRACTUAL ALLOW	235,737.88
NON-COVERD CHARGES	150,667.30	TOTAL MEDICAID LIAB	189,504.64
		LESS: COB	189,429.64
		LESS: COPAYMENT	75.00
		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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,818.00	196.50	OTHER LAB	16,169.00	0.00
MED/SURG SUPPLY	5,456.00	759.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	244.80	EDUCATION & TRAINING	225.00	0.00
RADIOLOGY-DIAGNOSTIC	17,375.00	2,507.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,469.00	12,062.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,599.00	FEE SCHEDULE LAB	70,718.52	10,982.00
EKG/ECG	4,434.00	736.00	MRI SERVICES	4,291.00	9,720.00
IV THERAPY	3,693.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,749.00	44,334.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,934.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,490.00	171.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,439.00	2,243.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,104.00	8,130.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,756.00	1,214.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,783.00	30,844.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	193.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	880.00	440.00	IMPL DEV CHARGE PATIENTS	1,458.00	345.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,825.00	7,656.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	16,484.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,983.00	0.00			

TOTAL ANCILLARY	425,242.52	150,667.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	425,242.52	150,667.30

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	257,237.00	ADJUSTMENTS	1,660.81
COVERED CHARGES	234,960.00	CONTRACTUAL ALLOW	227,318.54
NON-COVERD CHARGES	22,277.00	TOTAL MEDICAID LIAB	7,641.46
		LESS: COB	43.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	7,418.46

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,668.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	138.00	390.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,238.00	2,445.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,447.00	11,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,488.00	215.00
EKG/ECG	1,840.00	0.00	MRI SERVICES	10,552.00	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	1,494.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,048.00	3,304.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,455.50	1,243.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,573.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	183.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,591.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	234,960.00	22,277.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	234,960.00	22,277.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,540.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,065.50	CONTRACTUAL ALLOW	19,046.97
NON-COVERD CHARGES	475.00	TOTAL MEDICAID LIAB	6,018.53
		LESS: COB	6,006.53
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164.00	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	551.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,172.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,833.00	33.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,551.00	442.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,794.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,065.50	475.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,065.50	475.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,073,198.70	ADJUSTMENTS	53,991.30
COVERED CHARGES	1,889,847.20	CONTRACTUAL ALLOW	1,697,745.76
NON-COVERD CHARGES	183,351.50	TOTAL MEDICAID LIAB	192,101.44
		LESS: COB	0.00
		LESS: COPAYMENT	122.25
		REIMBURSEMENT	191,979.19

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,582.50	0.00	OTHER LAB	265.00	0.00
MED/SURG SUPPLY	99,026.00	240.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,911.00	29,037.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,911.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,060.00	FEE SCHEDULE LAB	27,134.00	1,587.00
EKG/ECG	4,434.00	736.00	MRI SERVICES	4,291.00	0.00
IV THERAPY	15,803.00	382.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	394,637.00	101,694.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	996.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,151.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,456.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	489,573.50	28,528.50
RADIOLOGY THERAPEUTIC	72,163.00	3,965.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,283.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	418.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	532,272.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,521.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	860.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,928.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	115,155.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,855.20	0.00			

TOTAL ANCILLARY	1,889,847.20	183,351.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,889,847.20	183,351.50

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 FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,182.00	ADJUSTMENTS	0.00
COVERED CHARGES	55,509.00	CONTRACTUAL ALLOW	34,970.50
NON-COVERD CHARGES	23,673.00	TOTAL MEDICAID LIAB	20,538.50
		LESS: COB	20,529.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,394.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,281.00	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	2,980.00	197.00
EKG/ECG	368.00	736.00	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	1,984.00	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	2,990.00	11,527.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,329.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	597.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,399.00	11,213.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,187.00	0.00			

TOTAL ANCILLARY	55,509.00	23,673.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,509.00	23,673.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,173,562.92	ADJUSTMENTS	1,464,080.08
COVERED CHARGES	4,121,877.64	CONTRACTUAL ALLOW	1,870,543.92
NON-COVERD CHARGES	51,685.28	TOTAL MEDICAID LIAB	2,251,333.72
		LESS: COB	37,166.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,214,167.44

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,310	0	1,754,040.00	14,850.00
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	1,310	0	1,754,040.00	14,850.00
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	1,310	0	1,754,040.00	14,850.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338,681.30	2,621.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55,012.16	1,714.00	RECREATIONAL THERAPY	119.00	0.00
LABORATORY-GENERAL	139,976.90	8,552.92	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,552.00	515.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,201.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	684,874.47	7,840.08	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,477.44	0.00	MRI SERVICES	2,978.13	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	28,960.98	731.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,555.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,076.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	835,953.62	7,043.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	208,929.74	4,152.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	31,000.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	4,710.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,666.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	779.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,367,837.64	36,835.28
TOTAL ACCOMODATIONS	1,754,040.00	14,850.00
TOTAL CHARGES	4,121,877.64	51,685.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
6135 ROOSEVELT HWY
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	171,244,544.55	ADJUSTMENTS	4,272,306.47
COVERED CHARGES	164,031,309.18	CONTRACTUAL ALLOW	140,088,992.87
NON-COVERD CHARGES	7,213,235.37	TOTAL MEDICAID LIAB	23,942,316.31
		LESS: COB	139,810.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,802,505.90

TOTAL NUMBER OF ADMISSIONS 2,489

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,497	0	13,244,058.00	1,548,980.20
ROUTINE NURSERY	2,229	0	4,186,717.50	40,285.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,726	0	17,430,775.50	1,589,265.20
SPECIAL CARE SERVICES				
CCU	848	0	2,177,716.20	0.00
ICU	4,587	0	16,476,742.60	176,507.40
NICU	195	0	711,171.60	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	267	0	1,528,075.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,897	0	20,893,705.40	176,507.40
TOTAL ACCOMODATIONS	16,623	0	38,324,480.90	1,765,772.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,675,452.58	1,109,987.08	OTHER LAB	665,999.97	6,300.50
MED/SURG SUPPLY	7,752,341.70	258,464.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,824,336.00	180,940.39	EDUCATION & TRAINING	13,308.00	0.00
RADIOLOGY-DIAGNOSTIC	3,475,158.90	40,467.55	OTHER THERAPEUTIC SVC	0.00	6,880.00
CT SCAN	7,520,397.90	384,293.57	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,170,453.47	61,857.19	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	634,701.98	3,296.09	MRI SERVICES	2,146,433.25	16,012.56
IV THERAPY	720,665.68	1,287.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,656,452.01	255,233.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,910,736.09	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,232,942.70	88,637.99	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,529,534.37	71,602.43	AMBULANCE	0.00	0.00
GI SERVICES	203,614.65	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,376,310.23	49,040.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,580,920.82	15,919.46	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	580,117.18	3,604.78	INJECTABLE DRUGS	145.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	712,578.03	37,865.76	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511,032.15	5,234.65	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,751,957.86	33,977.13	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44,889.00	340.40	TRAUMA RESPONSE	0.00	2,089,750.07
PSYCHIATRIC SERVICES	467,684.35	0.00	IMPL DEV CHARGE PATIENTS	5,508,911.75	58,669.57
LITHOTRIPSY	74,983.04	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	770,029.62	1,200.79			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,024,438.07	621,480.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,043,370.15	10,410.00			
AUDIOLOGY	162,372.92	0.00			
CARDIOLOGY	2,520,410.14	34,343.17			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	217,644.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	226,503.71	365.00			

TOTAL ANCILLARY	125,706,828.28	5,447,462.77
TOTAL ACCOMODATIONS	38,324,480.90	1,765,772.60
TOTAL CHARGES	164,031,309.18	7,213,235.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	500,513.41	ADJUSTMENTS	0.00
COVERED CHARGES	476,803.61	CONTRACTUAL ALLOW	364,098.68
NON-COVERD CHARGES	23,709.80	TOTAL MEDICAID LIAB	112,704.93
		LESS: COB	112,704.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	58,818.00	2,440.80
ROUTINE NURSERY	7	0	4,631.40	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	0	63,449.40	2,440.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1	0	3,422.00	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	0	3,422.00	0.00
TOTAL ACCOMODATIONS	47	0	66,871.40	2,440.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,855.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,105.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,759.16	0.00	EDUCATION & TRAINING	320.00	0.00
RADIOLOGY-DIAGNOSTIC	2,545.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,337.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,559.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,824.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	114,797.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,316.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,430.37	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,799.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,336.00	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	442.20	691.00	TRAUMA RESPONSE	0.00	20,578.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,414.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,788.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,356.92	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	196.64	0.00			

TOTAL ANCILLARY	409,932.21	21,269.00
TOTAL ACCOMODATIONS	66,871.40	2,440.80
TOTAL CHARGES	476,803.61	23,709.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,429,890.03	ADJUSTMENTS	535,686.29
COVERED CHARGES	36,808,520.50	CONTRACTUAL ALLOW	33,516,924.58
NON-COVERD CHARGES	3,621,369.53	TOTAL MEDICAID LIAB	3,291,595.92
		LESS: COB	3,000.66
		LESS: COPAYMENT	6,029.62
		REIMBURSEMENT	3,282,565.64
		ALL OTHER	3,029,398.15
		FEE SCHEDULE-LAB	219,411.05
		INJECTABLE DRUGS	33,756.44

TOTAL NUMBER OF CLAIMS 8,441

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,137,498.01	609.02	OTHER LAB	244,505.76	1,990.00
MED/SURG SUPPLY	1,249,296.97	10,010.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,318,011.00	160,838.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,726,630.85	653,017.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,095.31	19,774.40	FEE SCHEDULE LAB	4,950,731.45	103,635.82
EKG/ECG	691,560.61	7,003.48	MRI SERVICES	802,909.13	87,030.83
IV THERAPY	1,556,317.20	77,208.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,998,445.61	503,084.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	684.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,531.73	17,643.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,040,343.24	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,445.49	3,379.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,625,781.72	121,319.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	331,058.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,865.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,596.27	409,383.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,782.35	9,295.22	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,971.36	1,644.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	308,766.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	95,920.24	10,911.23	TRAUMA RESPONSE	0.00	400,182.90
PSYCHIATRIC SERVICES	266,129.64	95,290.49	IMPL DEV CHARGE PATIENTS	180,181.87	11,894.70
LITHOTRIPSY	524,881.28	299,932.16	NO CC/INVALID REV CODE	77.00	80.00
OTHER IMAGING SERVICE	948,851.97	212,638.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,836.66	7,457.82			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	386,595.06	9,717.00			
AUDIOLOGY	13,440.54	2,135.97			
CARDIOLOGY	182,138.00	21,925.67			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	256,329.02	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	711,942.56	46,704.52			

TOTAL ANCILLARY	36,808,520.50	3,621,369.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,808,520.50	3,621,369.53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	5918171001287	03/27/18 - 03/27/18	06/25/18	77.00	0.00	0.00	0.00	20.52
780	5918171001287	03/27/18 - 03/27/18	06/25/18	0.00	80.00	0.00	0.00	0.00
TOTAL				77.00	80.00	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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	146,455.30	ADJUSTMENTS	0.00
COVERED CHARGES	86,296.30	CONTRACTUAL ALLOW	56,659.16
NON-COVERD CHARGES	60,159.00	TOTAL MEDICAID LIAB	29,637.14
		LESS: COB	29,632.23
		LESS: COPAYMENT	4.91
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920.33	420.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,333.40	860.72	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,789.05	20,736.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	512.03	FEE SCHEDULE LAB	10,052.76	160.00
EKG/ECG	470.87	0.00	MRI SERVICES	6,133.00	4,512.00
IV THERAPY	2,111.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	21,403.37	250.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,013.72	283.50
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	20,578.00
PSYCHIATRIC SERVICES	0.00	766.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,677.00	10,053.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,343.80	805.00			

TOTAL ANCILLARY	86,296.30	60,159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,296.30	60,159.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,648,690.10	ADJUSTMENTS	747.16
COVERED CHARGES	1,585,357.76	CONTRACTUAL ALLOW	1,549,130.56
NON-COVERD CHARGES	63,332.34	TOTAL MEDICAID LIAB	36,227.20
		LESS: COB	985.00
		LESS: COPAYMENT	1,461.00
		REIMBURSEMENT	33,781.20

TOTAL NUMBER OF CLAIMS 630

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,954.47	0.00	OTHER LAB	8,717.98	0.00
MED/SURG SUPPLY	11,010.68	158.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,573.55	12,328.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	206,330.01	31,828.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	291,497.12	1,995.33
EKG/ECG	22,788.97	0.00	MRI SERVICES	19,100.78	0.00
IV THERAPY	72,628.70	1,015.16	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	779,067.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,675.97	2,226.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	196.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,217.47	4,596.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,794.73	8,988.02			
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	0.00	0.00			

TOTAL ANCILLARY	1,585,357.76	63,332.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,585,357.76	63,332.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,312.37	ADJUSTMENTS	0.00
COVERED CHARGES	15,274.37	CONTRACTUAL ALLOW	13,222.36
NON-COVERD CHARGES	38.00	TOTAL MEDICAID LIAB	2,052.01
		LESS: COB	2,046.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.25	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	859.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,275.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,243.00	38.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,881.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,274.37	38.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,274.37	38.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,945,198.11	ADJUSTMENTS	36,794.16
COVERED CHARGES	1,815,697.06	CONTRACTUAL ALLOW	1,699,134.72
NON-COVERD CHARGES	129,501.05	TOTAL MEDICAID LIAB	116,562.34
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	116,487.34

TOTAL NUMBER OF CLAIMS 19

GEORGIA 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 ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,279.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	213,514.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,304.37	594.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,284.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,073.77	FEE SCHEDULE LAB	22,408.02	0.00
EKG/ECG	2,825.22	0.00	MRI SERVICES	6,513.39	0.00
IV THERAPY	2,839.14	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	315,039.92	83,457.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,777.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,457.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,843.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,132.74	18,846.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	662,371.96	0.00
LITHOTRIPSY	149,966.08	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,255.86	25,528.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,706.68	0.00			

TOTAL ANCILLARY	1,815,697.06	129,501.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,815,697.06	129,501.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,302,181.24	ADJUSTMENTS	57,046.48
COVERED CHARGES	2,279,316.24	CONTRACTUAL ALLOW	1,447,775.04
NON-COVERD CHARGES	22,865.00	TOTAL MEDICAID LIAB	831,541.20
		LESS: COB	3,486.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	828,054.28

TOTAL NUMBER OF ADMISSIONS 121

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	349	0	369,037.00	19,412.00
ROUTINE NURSERY	51	0	49,521.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	400	0	418,558.00	19,412.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	103	0	221,965.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	103	0	221,965.00	0.00
TOTAL ACCOMODATIONS	503	0	640,523.00	19,412.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490,213.28	0.00	OTHER LAB	7,259.00	0.00
MED/SURG SUPPLY	216,650.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	214,488.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	93,950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,171.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,685.00	0.00	MRI SERVICES	17,580.00	0.00
IV THERAPY	45,093.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	161,140.00	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	75,773.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,002.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,681.00	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	2,397.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,864.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,018.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,490.00	3,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,367.00	0.00			
AUDIOLOGY	6,336.00	0.00			
CARDIOLOGY	16,928.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,891.00	0.00			

TOTAL ANCILLARY	1,638,793.24	3,453.00
TOTAL ACCOMODATIONS	640,523.00	19,412.00
TOTAL CHARGES	2,279,316.24	22,865.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,120.78	ADJUSTMENTS	0.00
COVERED CHARGES	70,784.78	CONTRACTUAL ALLOW	20,951.38
NON-COVERD CHARGES	3,336.00	TOTAL MEDICAID LIAB	49,833.40
		LESS: COB	49,833.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	21	0	22,260.00	1,034.00
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	22,260.00	1,034.00
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	22,260.00	1,034.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,718.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,865.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,472.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,762.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	149.00	0.00	MRI SERVICES	2,700.00	0.00
IV THERAPY	932.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,613.00	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	1,207.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	632.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,698.00	2,302.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	747.00	0.00			

TOTAL ANCILLARY	48,524.78	2,302.00
TOTAL ACCOMODATIONS	22,260.00	1,034.00
TOTAL CHARGES	70,784.78	3,336.00

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 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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,992,072.28	ADJUSTMENTS	205,278.05
COVERED CHARGES	2,656,277.75	CONTRACTUAL ALLOW	1,905,161.65
NON-COVERD CHARGES	335,794.53	TOTAL MEDICAID LIAB	751,116.10
		LESS: COB	1,685.91
		LESS: COPAYMENT	2,103.29
		REIMBURSEMENT	747,326.90
		ALL OTHER	597,079.77
		FEE SCHEDULE-LAB	67,428.70
		INJECTABLE DRUGS	82,818.43

TOTAL NUMBER OF CLAIMS 2,109

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,068.44	1,056.60	OTHER LAB	46,964.00	8,665.00
MED/SURG SUPPLY	61,427.59	43.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	174.00	58.00
RADIOLOGY-DIAGNOSTIC	148,360.00	2,924.00	OTHER THERAPEUTIC SVC	252.00	1,851.00
CT SCAN	269,413.00	26,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,728.00	5,336.02	FEE SCHEDULE LAB	371,513.48	25,600.50
EKG/ECG	34,507.00	745.00	MRI SERVICES	91,824.00	9,384.00
IV THERAPY	125,447.00	17,366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,649.50	6,593.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,261.00	3,057.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,890.00	9,512.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,738.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	575,562.00	13,865.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,802.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285,871.41	69,977.24
RADIOLOGY THERAPEUTIC	177,577.00	102,988.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	177.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,496.00	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	NO CC/INVALID REV CODE	0.00	52.00
OTHER IMAGING SERVICE	85,483.00	14,894.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,366.00	2,592.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,318.00	2,515.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,682.00	600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,598.33	9,389.67			

TOTAL ANCILLARY	2,656,277.75	335,794.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,656,277.75	335,794.53

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 05/01/17 THROUGH 04/30/18
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
8369	2218040009414	11/03/17 - 11/03/17	02/12/18	0.00	52.00	0.00	0.00	0.00
TOTAL				0.00	52.00	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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,931.74	ADJUSTMENTS	0.00
COVERED CHARGES	38,682.24	CONTRACTUAL ALLOW	14,845.96
NON-COVERD CHARGES	9,249.50	TOTAL MEDICAID LIAB	23,836.28
		LESS: COB	23,815.28
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,213.19	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	125.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,032.00	397.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,766.00	3,893.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,831.00	263.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,379.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	449.00	426.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	471.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,565.00	1,711.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	680.05	1,218.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	586.00	1,341.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,163.00	0.00			

TOTAL ANCILLARY	38,682.24	9,249.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,682.24	9,249.50

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	175,586.27	ADJUSTMENTS	806.10
COVERED CHARGES	166,579.77	CONTRACTUAL ALLOW	155,503.65
NON-COVERD CHARGES	9,006.50	TOTAL MEDICAID LIAB	11,076.12
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	10,749.12
		TOTAL NUMBER OF CLAIMS	198

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,235.00	0.00	OTHER LAB	0.00	1,602.00
MED/SURG SUPPLY	911.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,564.00	823.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,193.00	2,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,642.00	1,408.00
EKG/ECG	1,043.00	0.00	MRI SERVICES	1,860.00	0.00
IV THERAPY	7,404.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	314.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,430.00	725.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,424.80	1,259.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,558.00	755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,000.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	166,579.77	9,006.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	166,579.77	9,006.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,686.10	ADJUSTMENTS	0.00
COVERED CHARGES	2,670.10	CONTRACTUAL ALLOW	1,401.56
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	1,268.54
		LESS: COB	1,262.54
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	213.00	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	451.00	16.00
EKG/ECG	149.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	340.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,348.00	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	108.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,670.10	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,670.10	16.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	140,466.98	ADJUSTMENTS	29,178.34
COVERED CHARGES	136,808.78	CONTRACTUAL ALLOW	101,628.30
NON-COVERD CHARGES	3,658.20	TOTAL MEDICAID LIAB	35,180.48
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	35,153.48

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,410.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	433.00	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	123.00
CT SCAN	1,459.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,201.00	180.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,080.00	914.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,597.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86,334.00	36.20
RADIOLOGY THERAPEUTIC	3,883.00	303.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,062.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,994.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	930.00	2,102.00			

TOTAL ANCILLARY	136,808.78	3,658.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,808.78	3,658.20

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,666,469.99	ADJUSTMENTS	909,462.80
COVERED CHARGES	30,019,498.90	CONTRACTUAL ALLOW	20,448,495.15
NON-COVERD CHARGES	646,971.09	TOTAL MEDICAID LIAB	9,571,003.75
		LESS: COB	38,311.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,532,692.64

TOTAL NUMBER OF ADMISSIONS 905

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,699	0	3,893,819.00	393,669.00
ROUTINE NURSERY	222	0	215,651.00	72.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,921	0	4,109,470.00	393,741.00
SPECIAL CARE SERVICES				
CCU	364	0	785,663.00	0.00
ICU	1,940	0	3,343,940.00	0.00
NICU	8	0	14,064.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,312	0	4,143,667.00	0.00
TOTAL ACCOMODATIONS	6,233	0	8,253,137.00	393,741.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,209,605.55	10.20	OTHER LAB	106,245.00	0.00
MED/SURG SUPPLY	2,047,054.76	6,364.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,393,565.54	4,327.00	EDUCATION & TRAINING	1,588.00	0.00
RADIOLOGY-DIAGNOSTIC	460,129.00	0.00	OTHER THERAPEUTIC SVC	0.00	366.00
CT SCAN	467,879.00	176,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	211,740.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	112,579.00	0.00	MRI SERVICES	293,384.00	0.00
IV THERAPY	614,326.00	2,069.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,584,818.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	167,965.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,234,858.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	484,201.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408,544.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	190,627.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	107,348.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	212,684.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	44,700.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	343,302.00	2,302.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,091.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,900.00
OTHER IMAGING SERVICE	72,786.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	448,041.00	38,041.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,656.89	4,024.89			
AUDIOLOGY	26,928.00	0.00			
CARDIOLOGY	1,120,290.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,638.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	266,788.00	0.00			

TOTAL ANCILLARY	21,766,361.90	253,230.09
TOTAL ACCOMODATIONS	8,253,137.00	393,741.00
TOTAL CHARGES	30,019,498.90	646,971.09

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 05/01/17 THROUGH 04/30/18
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	2017189003001	06/27/17 - 06/30/17	07/17/17	0.00	2,700.00	0.00	0.00	0.00
615	2218024000648	01/09/18 - 01/14/18	01/29/18	0.00	2,700.00	0.00	0.00	0.00
615	2018041000181	01/03/18 - 01/05/18	02/19/18	0.00	2,700.00	0.00	0.00	0.00
615	2218080000736	03/02/18 - 03/15/18	03/26/18	0.00	2,700.00	0.00	0.00	0.00
615	2218144014388	04/29/18 - 05/14/18	05/28/18	0.00	2,700.00	0.00	0.00	0.00
615	2018265025635	05/24/17 - 05/26/17	10/01/18	0.00	2,700.00	0.00	0.00	0.00
615	2019107012250	03/05/18 - 03/07/18	04/22/19	0.00	2,700.00	0.00	0.00	0.00
TOTAL				0.00	18,900.00	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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,030.79	ADJUSTMENTS	0.00
COVERED CHARGES	190,177.79	CONTRACTUAL ALLOW	55,407.20
NON-COVERD CHARGES	7,853.00	TOTAL MEDICAID LIAB	134,770.59
		LESS: COB	134,770.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	37	0	38,905.00	2,620.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	37	0	38,905.00	2,620.00
SPECIAL CARE SERVICES				
CCU	1	0	2,155.00	0.00
ICU	5	0	8,110.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	10,265.00	0.00
TOTAL ACCOMODATIONS	43	0	49,170.00	2,620.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,521.29	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,685.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,143.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,170.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,918.00	1,780.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	632.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,398.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,862.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	432.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,045.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,232.00	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	3,797.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	462.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,396.00	3,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,673.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,035.00	0.00			

TOTAL ANCILLARY	141,007.79	5,233.00
TOTAL ACCOMODATIONS	49,170.00	2,620.00
TOTAL CHARGES	190,177.79	7,853.00

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 SYSTEM INC
2415 PARKWOOD DRIVE
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,627,057.04	ADJUSTMENTS	860,449.00
COVERED CHARGES	10,245,069.86	CONTRACTUAL ALLOW	7,406,750.77
NON-COVERD CHARGES	1,381,987.18	TOTAL MEDICAID LIAB	2,838,319.09
		LESS: COB	2,150.71
		LESS: COPAYMENT	8,074.48
		REIMBURSEMENT	2,828,093.90
		ALL OTHER	2,155,188.92
		FEE SCHEDULE-LAB	233,753.07
		INJECTABLE DRUGS	439,151.91

TOTAL NUMBER OF CLAIMS 6,342

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,581.53	7,297.79	OTHER LAB	156,927.00	19,733.00
MED/SURG SUPPLY	471,483.38	849.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	155.00	EDUCATION & TRAINING	116.00	59.00
RADIOLOGY-DIAGNOSTIC	466,687.00	15,833.00	OTHER THERAPEUTIC SVC	878.00	7,889.00
CT SCAN	838,557.00	223,313.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,339.00	21,059.06	FEE SCHEDULE LAB	1,222,307.00	74,211.00
EKG/ECG	98,372.00	2,384.00	MRI SERVICES	306,618.00	37,876.00
IV THERAPY	387,864.00	16,882.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	723,736.42	148,794.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,117.00	12,796.00	REHAB THERAPY	1,008.00	0.00
RESPIRATORY SERVICES	220,453.00	14,564.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,962.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,777.00	2,258.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,402,457.00	22,114.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,506.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261,599.42	239,064.17
RADIOLOGY THERAPEUTIC	751,822.00	277,797.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,655.00	5,310.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,849.00	1,818.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,426.00	1,500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,016.00	969.00
LITHOTRIPSY	30,393.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	402,356.00	41,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,157.00	1,296.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	111,555.00	15,192.57			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,895.00	143,907.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,880.00	564.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	324,720.11	25,265.91			

TOTAL ANCILLARY	10,245,069.86	1,381,987.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,245,069.86	1,381,987.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	273,208.47	ADJUSTMENTS	0.00
COVERED CHARGES	193,439.27	CONTRACTUAL ALLOW	52,338.00
NON-COVERD CHARGES	79,769.20	TOTAL MEDICAID LIAB	141,101.27
		LESS: COB	140,924.76
		LESS: COPAYMENT	176.51
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 100

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,723.02	72.40	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	17,962.00	292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,519.00	0.00	OTHER THERAPEUTIC SVC	0.00	126.00
CT SCAN	20,781.00	13,659.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,221.00	2,023.00
EKG/ECG	2,086.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,000.00	1,558.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,441.00	23,499.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,845.00	2,078.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	471.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,060.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,146.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,719.00	630.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,835.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,454.25	13,368.80
RADIOLOGY THERAPEUTIC	3,701.00	7,920.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,950.00	6,753.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,994.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,640.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,215.00	4,004.00			

TOTAL ANCILLARY	193,439.27	79,769.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	193,439.27	79,769.20

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	536,897.48	ADJUSTMENTS	1,543.48
COVERED CHARGES	502,672.88	CONTRACTUAL ALLOW	473,584.08
NON-COVERD CHARGES	34,224.60	TOTAL MEDICAID LIAB	29,088.80
		LESS: COB	12.78
		LESS: COPAYMENT	1,032.00
		REIMBURSEMENT	28,044.02

TOTAL NUMBER OF CLAIMS 520

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,825.43	146.40	OTHER LAB	1,848.00	0.00
MED/SURG SUPPLY	8,647.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,671.00	949.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,966.00	17,583.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,872.00	426.00	FEE SCHEDULE LAB	79,014.00	6,218.00
EKG/ECG	7,301.00	0.00	MRI SERVICES	1,860.00	3,720.00
IV THERAPY	18,862.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	591.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,711.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	238,515.00	504.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,457.45	1,981.20
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,530.00	924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,849.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,182.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,163.00	0.00			

TOTAL ANCILLARY	502,672.88	34,224.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	502,672.88	34,224.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,505.60	ADJUSTMENTS	0.00
COVERED CHARGES	6,457.60	CONTRACTUAL ALLOW	2,907.37
NON-COVERD CHARGES	48.00	TOTAL MEDICAID LIAB	3,550.23
		LESS: COB	3,547.23
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121.00	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	993.00	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	796.00	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	554.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,375.00	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	108.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,510.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,457.60	48.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,457.60	48.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,816,610.61	ADJUSTMENTS	159,467.37
COVERED CHARGES	1,652,978.70	CONTRACTUAL ALLOW	1,334,782.35
NON-COVERD CHARGES	163,631.91	TOTAL MEDICAID LIAB	318,196.35
		LESS: COB	0.00
		LESS: COPAYMENT	431.37
		REIMBURSEMENT	317,764.98
		TOTAL NUMBER OF CLAIMS	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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,939.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	455,881.26	3,742.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	236.00
RADIOLOGY-DIAGNOSTIC	17,308.00	22,230.00	OTHER THERAPEUTIC SVC	126.00	504.00
CT SCAN	2,755.00	3,040.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	203.00	FEE SCHEDULE LAB	11,189.00	2,087.00
EKG/ECG	1,639.00	1,192.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,069.00	498.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	399,040.66	5,522.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,180.00	1,892.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,324.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,516.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,836.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285,550.85	14,221.57
RADIOLOGY THERAPEUTIC	209,795.00	31,523.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	408.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,992.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	804.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,168.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	120,381.00	73,418.00			
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	17,484.20	2,915.00			

TOTAL ANCILLARY	1,652,978.70	163,631.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,652,978.70	163,631.91

GEORGIA DEPARTMENT OF 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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,451.82	ADJUSTMENTS	0.00
COVERED CHARGES	21,563.02	CONTRACTUAL ALLOW	8,787.11
NON-COVERD CHARGES	888.80	TOTAL MEDICAID LIAB	12,775.91
		LESS: COB	12,769.91
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	926.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,607.00	146.00	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	289.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,390.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	856.00	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	217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277.70	720.80
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,563.02	888.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,563.02	888.80

** 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,718,985.22	ADJUSTMENTS	95,503.72
COVERED CHARGES	14,204,391.24	CONTRACTUAL ALLOW	11,429,354.75
NON-COVERD CHARGES	514,593.98	TOTAL MEDICAID LIAB	2,775,036.49
		LESS: COB	34,447.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,740,588.76

TOTAL NUMBER OF ADMISSIONS 327

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	578	0	527,481.00	167,741.43
ROUTINE NURSERY	90	0	81,457.21	2,727.42
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	668	0	608,938.21	170,468.85
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	601	0	1,602,042.67	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	601	0	1,602,042.67	0.00
TOTAL ACCOMODATIONS	1,269	0	2,210,980.88	170,468.85

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	523,084.93	0.00	OTHER LAB	17,381.49	0.00
MED/SURG SUPPLY	182,962.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,982,029.27	0.00	EDUCATION & TRAINING	224.00	0.00
RADIOLOGY-DIAGNOSTIC	202,159.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,938.25	319,218.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,348.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226,998.16	0.00	MRI SERVICES	78,161.85	0.00
IV THERAPY	100,528.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,246,935.79	2,163.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	210,657.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,325,193.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	444,002.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,824.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,321.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	105,592.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	118,671.80	0.00	INJECTABLE DRUGS	1,922,805.04	0.00
RADIOLOGY THERAPEUTIC	42,316.01	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,919.65	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.74	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,111,384.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,051.55	8,102.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,958.00	3,912.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	90,045.20	10,728.15			
AUDIOLOGY	8,810.08	0.00			
CARDIOLOGY	274,789.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,326.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,844.83	0.00			

TOTAL ANCILLARY	11,993,410.36	344,125.13
TOTAL ACCOMODATIONS	2,210,980.88	170,468.85
TOTAL CHARGES	14,204,391.24	514,593.98

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,451.67	ADJUSTMENTS	0.00
COVERED CHARGES	11,081.10	CONTRACTUAL ALLOW	4,504.80
NON-COVERD CHARGES	370.57	TOTAL MEDICAID LIAB	6,576.30
		LESS: COB	6,576.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	870.00	370.57
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	870.00	370.57
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	870.00	370.57

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	665.90	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	7,802.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,248.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,211.10	0.00
TOTAL ACCOMODATIONS	870.00	370.57
TOTAL CHARGES	11,081.10	370.57

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,573,374.72	ADJUSTMENTS	233,435.90
COVERED CHARGES	15,657,386.14	CONTRACTUAL ALLOW	13,923,857.97
NON-COVERD CHARGES	2,915,988.58	TOTAL MEDICAID LIAB	1,733,528.17
		LESS: COB	3,908.62
		LESS: COPAYMENT	6,010.21
		REIMBURSEMENT	1,723,609.34
		ALL OTHER	1,445,725.65
		FEE SCHEDULE-LAB	168,048.16
		INJECTABLE DRUGS	109,835.53

TOTAL NUMBER OF CLAIMS 5,045

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,561.34	55,964.25	OTHER LAB	45,064.10	0.00
MED/SURG SUPPLY	174,314.90	869.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	44.80
RADIOLOGY-DIAGNOSTIC	557,949.85	36,486.00	OTHER THERAPEUTIC SVC	0.00	1,465.20
CT SCAN	1,597,261.49	160,142.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	293,908.99	9,135.75	FEE SCHEDULE LAB	2,704,417.38	344,889.80
EKG/ECG	304,150.06	12,321.38	MRI SERVICES	467,143.31	16,578.56
IV THERAPY	827,195.28	152,493.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,491,789.23	683,680.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,438.35	8,603.49	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,403.73	3,715.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	470,020.50	2,579.53	AMBULANCE	0.00	0.00
GI SERVICES	85,018.50	19,762.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,283,644.43	11,727.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	165,709.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,003,728.79	576,009.40
RADIOLOGY THERAPEUTIC	602,864.87	370,763.52	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	748.82	698.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	365.51	2,582.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,456.51	187,511.26
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,844.34
OTHER IMAGING SERVICE	413,265.09	29,887.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,055.26	45,214.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	240,095.24	99,054.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	265,678.76	66,866.34			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	244,409.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	243,727.45	14,096.01			

TOTAL ANCILLARY	15,657,386.14	2,915,988.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,657,386.14	2,915,988.58

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 01/01/18 THROUGH 12/31/18
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	2018346086924	12/04/18 - 12/04/18	12/17/18	0.00	2,844.34	0.00	0.00	0.00
TOTAL				0.00	2,844.34	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	155,522.27	ADJUSTMENTS	0.00
COVERED CHARGES	125,704.20	CONTRACTUAL ALLOW	69,613.35
NON-COVERD CHARGES	29,818.07	TOTAL MEDICAID LIAB	56,090.85
		LESS: COB	56,025.00
		LESS: COPAYMENT	65.85
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,429.21	91.00	OTHER LAB	1,674.31	0.00
MED/SURG SUPPLY	1,547.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,481.50	763.93	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,221.23	7,274.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,488.64	2,921.02
EKG/ECG	6,267.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,822.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,393.40	16,417.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394.01	788.02	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,650.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,462.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,926.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,471.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,243.39	532.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,626.94	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	246.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	430.82	783.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,173.16	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	125,704.20	29,818.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	125,704.20	29,818.07

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	460,251.68	ADJUSTMENTS	5,238.40
COVERED CHARGES	439,030.87	CONTRACTUAL ALLOW	423,669.48
NON-COVERD CHARGES	21,220.81	TOTAL MEDICAID LIAB	15,361.39
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	14,971.39
		TOTAL NUMBER OF CLAIMS	248

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	983.46	91.00	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	16,649.28	2,076.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,444.93	5,580.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	88,384.04	7,571.49
EKG/ECG	2,961.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,137.18	1,509.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	711.54	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	256,445.85	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	8,236.80	512.24
RADIOLOGY THERAPEUTIC	1,990.00	282.68	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.84	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,983.65	3,596.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	439,030.87	21,220.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	439,030.87	21,220.81

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,405.79	ADJUSTMENTS	0.00
COVERED CHARGES	3,405.79	CONTRACTUAL ALLOW	2,375.39
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,030.40
		LESS: COB	1,027.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	438.11	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	2,957.75	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	9.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,405.79	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,405.79	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,621,394.22	ADJUSTMENTS	60,910.53
COVERED CHARGES	2,260,204.84	CONTRACTUAL ALLOW	1,938,581.50
NON-COVERD CHARGES	361,189.38	TOTAL MEDICAID LIAB	321,623.34
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	321,281.34

TOTAL NUMBER OF CLAIMS 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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,819.79	2,090.94	OTHER LAB	591.56	0.00
MED/SURG SUPPLY	69,641.86	744.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,802.25	1,376.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,042.45	2,926.87	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,128.44	FEE SCHEDULE LAB	32,412.41	3,418.86
EKG/ECG	5,429.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,283.78	18,937.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	551,855.93	39,378.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	570.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	112,716.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,829.79	502.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,583.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,226,453.14	52,796.41
RADIOLOGY THERAPEUTIC	139,850.14	50,644.98	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	86.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,767.14	182,685.44
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,422.79	606.02			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,144.36	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,989.16	866.36			

TOTAL ANCILLARY	2,260,204.84	361,189.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,260,204.84	361,189.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	165,784.08	ADJUSTMENTS	0.00
COVERED CHARGES	128,972.21	CONTRACTUAL ALLOW	29,442.21
NON-COVERD CHARGES	36,811.87	TOTAL MEDICAID LIAB	99,530.00
		LESS: COB	99,512.00
		LESS: COPAYMENT	18.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494.65	600.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,561.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	174.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,029.77	FEE SCHEDULE LAB	6,262.16	1,056.19
EKG/ECG	987.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	661.55	3,212.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	84,018.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,812.00	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	2,942.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,811.07	433.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	30,480.03
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.29	0.00			

TOTAL ANCILLARY	128,972.21	36,811.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	128,972.21	36,811.87

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,862,783.07	ADJUSTMENTS	178,277.50
COVERED CHARGES	1,825,273.07	CONTRACTUAL ALLOW	938,974.28
NON-COVERD CHARGES	37,510.00	TOTAL MEDICAID LIAB	886,298.79
		LESS: COB	7,841.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	878,457.39

TOTAL NUMBER OF ADMISSIONS 179

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	290	0	186,492.00	36,108.00
ROUTINE NURSERY	104	0	63,856.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	394	0	250,348.00	36,108.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	54	0	97,416.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	97,416.00	0.00
TOTAL ACCOMODATIONS	448	0	347,764.00	36,108.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,315.92	0.00	OTHER LAB	1,784.00	0.00
MED/SURG SUPPLY	153,745.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	278,244.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,198.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,674.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,103.00	0.00	MRI SERVICES	4,096.00	0.00
IV THERAPY	1,696.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	199,753.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	181,189.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,529.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,399.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,201.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,066.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,040.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,842.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,917.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,362.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,179.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,610.00	1,402.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	25,075.00	0.00			
CARDIOLOGY	14,574.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,434.00	0.00			

TOTAL ANCILLARY	1,477,509.07	1,402.00
TOTAL ACCOMODATIONS	347,764.00	36,108.00
TOTAL CHARGES	1,825,273.07	37,510.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,045,939.83	ADJUSTMENTS	143,247.44
COVERED CHARGES	2,782,453.91	CONTRACTUAL ALLOW	2,212,702.90
NON-COVERD CHARGES	263,485.92	TOTAL MEDICAID LIAB	569,751.01
		LESS: COB	685.91
		LESS: COPAYMENT	1,722.00
		REIMBURSEMENT	567,343.10
		ALL OTHER	476,406.38
		FEE SCHEDULE-LAB	85,015.98
		INJECTABLE DRUGS	5,920.74

TOTAL NUMBER OF CLAIMS 2,302

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,592.40	108.00	OTHER LAB	13,088.00	0.00
MED/SURG SUPPLY	163,359.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176,910.00	2,827.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	362,097.00	40,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,973.00	8,115.00	FEE SCHEDULE LAB	616,182.56	30,863.00
EKG/ECG	16,703.00	321.00	MRI SERVICES	14,740.00	6,201.00
IV THERAPY	29,164.00	1,632.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	311,153.62	84,067.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,394.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,603.00	12,899.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,536.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,312.33	6,528.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	478,359.00	3,244.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,218.00	6,044.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69,422.00	28,639.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,678.00	3,309.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	655.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,595.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,245.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,041.00	9,624.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,056.00	1,906.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,164.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	119,463.00	14,143.00			

TOTAL ANCILLARY	2,782,453.91	263,485.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,782,453.91	263,485.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,127.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,108.00	CONTRACTUAL ALLOW	-2,672.85
NON-COVERD CHARGES	7,019.00	TOTAL MEDICAID LIAB	8,780.85
		LESS: COB	8,780.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317.00	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	793.00	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	892.00	56.00
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	6,902.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,158.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,594.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277.00	56.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,108.00	7,019.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,108.00	7,019.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,399.00	ADJUSTMENTS	804.76
COVERED CHARGES	58,894.00	CONTRACTUAL ALLOW	54,105.48
NON-COVERD CHARGES	2,505.00	TOTAL MEDICAID LIAB	4,788.52
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	4,677.52
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	671.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,839.00	741.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,704.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,644.00	1,677.00
EKG/ECG	321.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,256.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,243.00	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	1,601.00	87.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	58,894.00	2,505.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,894.00	2,505.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	882.00	ADJUSTMENTS	0.00
COVERED CHARGES	811.00	CONTRACTUAL ALLOW	178.94
NON-COVERD CHARGES	71.00	TOTAL MEDICAID LIAB	632.06
		LESS: COB	632.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	15.00	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	361.00	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	102.00	56.00
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	348.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	811.00	71.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	811.00	71.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,856.00	ADJUSTMENTS	5,545.23
COVERED CHARGES	136,157.33	CONTRACTUAL ALLOW	108,431.18
NON-COVERD CHARGES	24,698.67	TOTAL MEDICAID LIAB	27,726.15
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	27,699.15

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,549.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,791.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	291.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,278.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	254.00	FEE SCHEDULE LAB	4,224.00	1,563.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,518.00	136.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,976.33	13,838.67	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	4,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,483.00	7,492.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	55.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,440.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,516.00	1,360.00			

TOTAL ANCILLARY	136,157.33	24,698.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,157.33	24,698.67

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GRADY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	599,340,814.32	ADJUSTMENTS	24,887,071.69
COVERED CHARGES	574,022,597.13	CONTRACTUAL ALLOW	460,883,256.68
NON-COVERD CHARGES	25,318,217.19	TOTAL MEDICAID LIAB	113,139,340.45
		LESS: COB	439,038.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	112,700,302.14

TOTAL NUMBER OF ADMISSIONS 7,180

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	34,155	0	59,343,910.00	7,788,886.00
ROUTINE NURSERY	5,126	0	11,774,373.00	1,506,447.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	273,558.53
TOTAL ROUTINE	39,281	0	71,118,283.00	9,568,892.03
SPECIAL CARE SERVICES				
CCU	694	0	2,320,426.00	30,402.00
ICU	14,509	0	60,461,813.00	807,416.00
NICU	383	0	2,197,188.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	401	0	2,356,352.00	0.00
BURN UNIT	926	0	6,808,449.00	620,704.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	16,913	0	74,144,228.00	1,458,522.00
TOTAL ACCOMODATIONS	56,194	0	145,262,511.00	11,027,414.03

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,659,896.33	547,898.00	OTHER LAB	2,412,103.00	9,769.00
MED/SURG SUPPLY	15,189,466.95	508,936.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,119,473.05	1,490,033.42	EDUCATION & TRAINING	1,513.00	0.00
RADIOLOGY-DIAGNOSTIC	12,794,788.50	61,891.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,400,667.00	749,420.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,260,469.65	774,915.09	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,528,496.00	22,540.00	MRI SERVICES	6,589,110.00	32,586.00
IV THERAPY	1,363,422.00	211,522.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	96,174,872.00	1,080,097.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,148,557.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,035,303.58	1,458,049.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,922,589.50	142,077.00	AMBULANCE	0.00	0.00
GI SERVICES	1,428,552.00	7,614.00	CAST ROOM	13,025.00	0.00
EMERGENCY ROOM	19,150,091.00	69,904.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,901,854.50	116,395.00	DRUG-SPECIFIC/HOME IV	0.00	307,512.43
LABORATORY PATHOLOGIC	2,235,866.00	35,684.00	INJECTABLE DRUGS	17,534,024.26	209,351.17
RADIOLOGY THERAPEUTIC	913,762.00	63,969.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,026,544.18	261,950.07	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,869,156.62	31,488.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,496,032.00	1,399,368.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,189.00	280,341.00	TRAUMA RESPONSE	0.00	267,290.00
PSYCHIATRIC SERVICES	7,667.00	0.00	IMPL DEV CHARGE PATIENTS	6,304,742.01	25,811.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,034,136.50	52,828.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,145,561.50	3,912,968.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,323,796.00	115,858.00			
AUDIOLOGY	415,252.00	495.00			
CARDIOLOGY	10,503,831.00	32,098.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,881,064.00	10,144.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,973,212.00	0.00			

TOTAL ANCILLARY	428,760,086.13	14,290,803.16
TOTAL ACCOMODATIONS	145,262,511.00	11,027,414.03
TOTAL CHARGES	574,022,597.13	25,318,217.19

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	976,635.95	ADJUSTMENTS	0.00
COVERED CHARGES	927,608.95	CONTRACTUAL ALLOW	436,982.49
NON-COVERD CHARGES	49,027.00	TOTAL MEDICAID LIAB	490,626.46
		LESS: COB	490,626.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	56	0	101,355.00	5,438.00
ROUTINE NURSERY	5	0	4,795.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	61	0	106,150.00	5,438.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	23,646.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	5	0	39,160.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	12	0	62,806.00	0.00
TOTAL ACCOMODATIONS	73	0	168,956.00	5,438.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,049.20	0.00	OTHER LAB	4,374.00	0.00
MED/SURG SUPPLY	15,609.32	348.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,999.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,001.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,685.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,904.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,410.00	0.00	MRI SERVICES	4,957.00	0.00
IV THERAPY	529.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	269,085.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,783.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,698.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,643.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,692.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,554.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,660.00	0.00	INJECTABLE DRUGS	20,292.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,520.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,654.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	701.00	TRAUMA RESPONSE	0.00	29,964.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,705.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,779.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,743.00	12,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	878.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,448.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	758,652.95	43,589.00
TOTAL ACCOMODATIONS	168,956.00	5,438.00
TOTAL CHARGES	927,608.95	49,027.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	180,190,700.30	ADJUSTMENTS	2,123,223.64
COVERED CHARGES	164,218,208.07	CONTRACTUAL ALLOW	138,743,939.88
NON-COVERD CHARGES	15,972,492.23	TOTAL MEDICAID LIAB	25,474,268.19
		LESS: COB	50,344.87
		LESS: COPAYMENT	161,807.75
		REIMBURSEMENT	25,262,115.57
		ALL OTHER	20,897,895.22
		FEE SCHEDULE-LAB	2,453,714.92
		INJECTABLE DRUGS	1,910,505.43

TOTAL NUMBER OF CLAIMS 79,497

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	701,329.08	191,708.91	OTHER LAB	2,554,803.00	58,845.00
MED/SURG SUPPLY	972,209.36	33,494.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	918.00	EDUCATION & TRAINING	0.00	23,963.00
RADIOLOGY-DIAGNOSTIC	8,104,215.00	170,657.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,725,552.00	1,990,840.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	648,599.00	829,998.02	FEE SCHEDULE LAB	43,720,903.00	1,999,583.00
EKG/ECG	3,114,270.00	89,528.00	MRI SERVICES	3,359,257.00	596,294.00
IV THERAPY	1,495,221.00	74,448.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,208,415.51	1,513,783.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	557,360.00	68,149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,898,646.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,601,345.07	403,168.93	CAST ROOM	11,776.00	0.00
EMERGENCY ROOM	31,241,254.00	994,892.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,050,291.00	0.00	DRUG-SPECIFIC/HOME IV	14,829.71	122,380.92
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,825,665.20	3,417,361.32
RADIOLOGY THERAPEUTIC	2,180,365.47	630,450.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	284,568.00	82,725.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	38,730.00	21,143.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,164.00	PATIENT CONVENIENCE	0.00	351.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,582,624.00	745,517.00	TRAUMA RESPONSE	0.00	50,878.00
PSYCHIATRIC SERVICES	575,144.00	159,266.04	IMPL DEV CHARGE PATIENTS	283,553.67	17,958.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,121,000.00	254,564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	956,101.00	368,554.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,529,843.00	457,449.00			
AUDIOLOGY	7,974.00	3,282.00			
CARDIOLOGY	2,600,065.00	474,064.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	216,732.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,035,567.00	119,114.00			

TOTAL ANCILLARY	164,218,208.07	15,972,492.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	164,218,208.07	15,972,492.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	511,596.30	ADJUSTMENTS	0.00
COVERED CHARGES	429,896.80	CONTRACTUAL ALLOW	212,976.12
NON-COVERD CHARGES	81,699.50	TOTAL MEDICAID LIAB	216,920.68
		LESS: COB	216,692.45
		LESS: COPAYMENT	228.23
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 186

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	994.76	143.34	OTHER LAB	3,026.00	388.00
MED/SURG SUPPLY	31.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	918.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,723.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,720.00	3,714.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	135,214.00	19,266.00
EKG/ECG	10,290.00	0.00	MRI SERVICES	14,429.00	0.00
IV THERAPY	5,857.00	1,179.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,732.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,857.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,896.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,205.00	9,500.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,755.04	6,626.16
RADIOLOGY THERAPEUTIC	1,805.00	10,026.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	9.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,317.00	2,774.00	TRAUMA RESPONSE	0.00	5,238.00
PSYCHIATRIC SERVICES	1,144.00	512.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,730.00	742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,817.00	16,768.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,372.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,378.00	0.00			

TOTAL ANCILLARY	429,896.80	81,699.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	429,896.80	81,699.50

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	910,038.93	ADJUSTMENTS	7,377.38
COVERED CHARGES	862,470.33	CONTRACTUAL ALLOW	839,130.27
NON-COVERD CHARGES	47,568.60	TOTAL MEDICAID LIAB	23,340.06
		LESS: COB	0.00
		LESS: COPAYMENT	1,023.00
		REIMBURSEMENT	22,317.06
		TOTAL NUMBER OF CLAIMS	381

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,358.88	1,107.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	637.00	46.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,156.00	3,185.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,416.00	19,664.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	143,980.00	6,233.00
EKG/ECG	17,640.00	980.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,179.00	150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	498,464.00	3,380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,718.45	11,411.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,875.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,315.00	1,412.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,574.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,749.00	0.00			
AUDIOLOGY	472.00	0.00			
CARDIOLOGY	17,856.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,080.00	0.00			

TOTAL ANCILLARY	862,470.33	47,568.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	862,470.33	47,568.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,614.86	ADJUSTMENTS	0.00
COVERED CHARGES	9,204.86	CONTRACTUAL ALLOW	6,422.80
NON-COVERD CHARGES	410.00	TOTAL MEDICAID LIAB	2,782.06
		LESS: COB	2,779.06
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139.86	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	3,101.00	410.00
EKG/ECG	980.00	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	4,984.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,204.86	410.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,204.86	410.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,512,876.77	ADJUSTMENTS	873,018.81
COVERED CHARGES	22,068,050.62	CONTRACTUAL ALLOW	18,174,932.56
NON-COVERD CHARGES	1,444,826.15	TOTAL MEDICAID LIAB	3,893,118.06
		LESS: COB	0.00
		LESS: COPAYMENT	1,893.00
		REIMBURSEMENT	3,891,225.06

TOTAL NUMBER OF CLAIMS 557

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,001.42	32,934.32	OTHER LAB	3,791.00	0.00
MED/SURG SUPPLY	323,562.50	6,089.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,072.00	48,268.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,221.00	13,789.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,883.00	FEE SCHEDULE LAB	463,033.00	13,030.00
EKG/ECG	4,410.00	5,880.00	MRI SERVICES	11,877.00	11,143.00
IV THERAPY	236,357.00	2,242.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,822,633.45	626,569.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,063.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,589,903.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,519.00	2,516.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,160,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,499,863.49	408,468.28
RADIOLOGY THERAPEUTIC	414,224.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,160.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	845.00	518.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	917,112.76	34,250.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,134.00	397.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,737.00	4,192.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,291.00	828.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	248,628.00	114,410.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	885,876.00	115,259.00			

TOTAL ANCILLARY	22,068,050.62	1,444,826.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,068,050.62	1,444,826.15

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,717.56	ADJUSTMENTS	0.00
COVERED CHARGES	20,717.56	CONTRACTUAL ALLOW	12,385.42
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,332.14
		LESS: COB	8,329.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	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	19,789.56	0.00
RADIOLOGY THERAPEUTIC	906.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,717.56	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,717.56	0.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,013,095.24	ADJUSTMENTS	20,477.56
COVERED CHARGES	2,001,165.53	CONTRACTUAL ALLOW	1,004,305.42
NON-COVERD CHARGES	11,929.71	TOTAL MEDICAID LIAB	996,860.11
		LESS: COB	29,645.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	967,215.02

TOTAL NUMBER OF ADMISSIONS 226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	391	0	179,860.00	0.00
ROUTINE NURSERY	140	0	42,100.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	460.00
TOTAL ROUTINE	531	0	221,960.00	460.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	62	0	68,200.00	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	62	0	68,200.00	0.00
TOTAL ACCOMODATIONS	593	0	290,160.00	460.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,198.86	0.00	OTHER LAB	2,286.00	0.00
MED/SURG SUPPLY	153,927.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	225,461.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,970.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,035.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,170.00	0.00	MRI SERVICES	4,098.75	0.00
IV THERAPY	273,234.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,776.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	219,752.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,531.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,061.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	84,586.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,615.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	566.00	0.00	INJECTABLE DRUGS	43,326.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,422.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	135.21
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,575.50	274.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,582.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,003.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,288.50	10,560.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,381.50	500.00			
AUDIOLOGY	15,019.75	0.00			
CARDIOLOGY	12,148.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,881.75	0.00			

TOTAL ANCILLARY	1,711,005.53	11,469.71
TOTAL ACCOMODATIONS	290,160.00	460.00
TOTAL CHARGES	2,001,165.53	11,929.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,015.15	ADJUSTMENTS	0.00
COVERED CHARGES	25,955.01	CONTRACTUAL ALLOW	7,832.62
NON-COVERD CHARGES	1,060.14	TOTAL MEDICAID LIAB	18,122.39
		LESS: COB	18,122.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	2,760.00	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	2,760.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,760.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,818.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,798.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,099.25	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	4,374.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,258.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,166.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,118.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,454.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	185.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	4.14
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	329.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	592.50	1,056.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,195.01	1,060.14
TOTAL ACCOMODATIONS	2,760.00	0.00
TOTAL CHARGES	25,955.01	1,060.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,978,757.42	ADJUSTMENTS	145,819.61
COVERED CHARGES	2,872,061.69	CONTRACTUAL ALLOW	2,198,346.28
NON-COVERD CHARGES	106,695.73	TOTAL MEDICAID LIAB	673,715.41
		LESS: COB	1,951.74
		LESS: COPAYMENT	1,418.41
		REIMBURSEMENT	670,345.26
		ALL OTHER	582,829.78
		FEE SCHEDULE-LAB	77,313.78
		INJECTABLE DRUGS	10,201.70

TOTAL NUMBER OF CLAIMS 1,958

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,032.43	0.00	OTHER LAB	78,908.25	0.00
MED/SURG SUPPLY	99,053.26	281.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,752.00	2,041.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	551,116.25	23,022.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,551.50	3,967.01	FEE SCHEDULE LAB	529,746.50	5,889.75
EKG/ECG	43,618.00	3,164.00	MRI SERVICES	61,934.75	0.00
IV THERAPY	25,805.25	16,594.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	76,676.00	8,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,594.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,144.25	1,450.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,588.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	916,683.50	21,064.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,116.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,945.63	4,267.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,884.25	678.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	789.50	567.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	13.95
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,188.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,362.12	1,050.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,772.00	3,432.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,033.75	1,584.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,624.75	2,939.00			
AUDIOLOGY	2,469.00	0.00			
CARDIOLOGY	14,278.50	1,070.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,580.75	2,025.75			

TOTAL ANCILLARY	2,872,061.69	106,695.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,872,061.69	106,695.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,419.44	ADJUSTMENTS	0.00
COVERED CHARGES	52,704.44	CONTRACTUAL ALLOW	31,524.47
NON-COVERD CHARGES	4,715.00	TOTAL MEDICAID LIAB	21,179.97
		LESS: COB	21,149.97
		LESS: COPAYMENT	30.00
		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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,427.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,963.45	418.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,493.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,524.25	1,967.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,362.75	FEE SCHEDULE LAB	6,612.00	68.00
EKG/ECG	565.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	136.75	159.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,085.75	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	2,659.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,629.50	355.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,914.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	171.13	12.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	84.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,058.50	287.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,732.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	731.50	0.00			

TOTAL ANCILLARY	52,704.44	4,715.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,704.44	4,715.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,272.22	ADJUSTMENTS	0.00
COVERED CHARGES	23,227.72	CONTRACTUAL ALLOW	20,654.48
NON-COVERD CHARGES	44.50	TOTAL MEDICAID LIAB	2,573.24
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	2,519.24
		TOTAL NUMBER OF CLAIMS	46

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220.66	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	852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,505.00	32.00
EKG/ECG	339.00	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	18,063.50	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	297.56	12.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,227.72	44.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,227.72	44.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,156.49	ADJUSTMENTS	0.00
COVERED CHARGES	11,964.49	CONTRACTUAL ALLOW	8,814.12
NON-COVERD CHARGES	192.00	TOTAL MEDICAID LIAB	3,150.37
		LESS: COB	3,150.37
		LESS: COPAYMENT	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

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	412.74	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	126.00	126.00	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	3,360.50	66.00
EKG/ECG	113.00	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	7,375.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,964.49	192.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,964.49	192.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,288.86	ADJUSTMENTS	5,566.29
COVERED CHARGES	19,094.86	CONTRACTUAL ALLOW	13,528.57
NON-COVERD CHARGES	194.00	TOTAL MEDICAID LIAB	5,566.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,566.29

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.38	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	252.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,435.00	0.00
EKG/ECG	113.00	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	5,011.75	194.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,773.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,094.86	194.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,094.86	194.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR
541 HISTORIC HWY, 441N
DEMOREST,GA 30535-0000

PROVIDER NUMBER
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	143,659,782.87	ADJUSTMENTS	5,025,835.90
COVERED CHARGES	136,764,677.09	CONTRACTUAL ALLOW	107,265,723.62
NON-COVERD CHARGES	6,895,105.78	TOTAL MEDICAID LIAB	29,498,953.47
		LESS: COB	149,170.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,349,783.37

TOTAL NUMBER OF ADMISSIONS 3,055

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,297	0	13,339,498.00	4,195,747.00
ROUTINE NURSERY	2,300	0	2,552,473.00	113,947.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14,597	0	15,891,971.00	4,309,694.00
SPECIAL CARE SERVICES				
CCU	303	0	601,708.00	0.00
ICU	2,505	0	5,923,152.00	0.00
NICU	18	0	38,160.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,826	0	6,563,020.00	0.00
TOTAL ACCOMODATIONS	17,423	0	22,454,991.00	4,309,694.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,573,166.81	277,639.00	OTHER LAB	851,085.00	1,353.00
MED/SURG SUPPLY	10,888,946.33	103,799.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,706,616.75	115,711.00	EDUCATION & TRAINING	933.00	0.00
RADIOLOGY-DIAGNOSTIC	1,153,831.00	2,785.00	OTHER THERAPEUTIC SVC	0.00	886.00
CT SCAN	7,057,879.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	690,812.00	5,658.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	714,585.00	1,861.00	MRI SERVICES	1,294,942.00	0.00
IV THERAPY	2,158,614.00	43,103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,681,983.00	55,630.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,020,701.00	9,904.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,419,327.01	22,536.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,615,390.00	11,677.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,132,452.00	3,998.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,580,012.00	19,780.00	DRUG-SPECIFIC/HOME IV	0.00	72,406.00
LABORATORY PATHOLOGIC	513,195.82	635.28	INJECTABLE DRUGS	80,255.00	0.00
RADIOLOGY THERAPEUTIC	221,674.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	276,674.00	936.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	337,185.00	2,337.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	879,330.00	357,655.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66,843.00	13,338.00	TRAUMA RESPONSE	0.00	135,054.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,017,981.07	8,619.58
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,259.00
OTHER IMAGING SERVICE	758,762.70	1,448.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	795,667.00	954,513.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	484,048.00	89,213.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,965,359.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	171,928.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,199,507.00	267,677.00			

TOTAL ANCILLARY	114,309,686.09	2,585,411.78
TOTAL ACCOMODATIONS	22,454,991.00	4,309,694.00
TOTAL CHARGES	136,764,677.09	6,895,105.78

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 10/01/17 THROUGH 09/30/18
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	2218303006918	02/15/18 - 03/22/18	11/05/18	0.00	5,259.00	0.00	0.00	0.00
TOTAL				0.00	5,259.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,561,414.24	ADJUSTMENTS	0.00
COVERED CHARGES	2,393,705.24	CONTRACTUAL ALLOW	1,092,641.56
NON-COVERD CHARGES	167,709.00	TOTAL MEDICAID LIAB	1,301,063.68
		LESS: COB	1,301,063.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	257	0	286,296.00	139,563.00
ROUTINE NURSERY	171	0	254,586.00	14,439.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	428	0	540,882.00	154,002.00
SPECIAL CARE SERVICES				
CCU	17	0	36,105.00	0.00
ICU	8	0	15,270.00	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	25	0	51,375.00	0.00
TOTAL ACCOMODATIONS	453	0	592,257.00	154,002.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,315.00	0.00	OTHER LAB	30,135.00	0.00
MED/SURG SUPPLY	235,813.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	192,063.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,624.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,645.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,048.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,497.00	0.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	225,913.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	198,141.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	91,105.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,201.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	165,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,852.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	709.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,426.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,622.00	1,488.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,693.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,357.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,168.00	3,682.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,143.00	1,426.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,628.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,464.00	7,061.00			

TOTAL ANCILLARY	1,801,448.24	13,707.00
TOTAL ACCOMODATIONS	592,257.00	154,002.00
TOTAL CHARGES	2,393,705.24	167,709.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,653,080.90	ADJUSTMENTS	937,151.97
COVERED CHARGES	41,034,312.15	CONTRACTUAL ALLOW	35,092,278.22
NON-COVERD CHARGES	9,618,768.75	TOTAL MEDICAID LIAB	5,942,033.93
		LESS: COB	2,175.41
		LESS: COPAYMENT	12,662.27
		REIMBURSEMENT	5,927,196.25
		ALL OTHER	4,967,976.58
		FEE SCHEDULE-LAB	506,831.43
		INJECTABLE DRUGS	452,388.24

TOTAL NUMBER OF CLAIMS 11,317

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,996.80	522,047.39	OTHER LAB	538,002.00	4,600.00
MED/SURG SUPPLY	895,162.18	339,215.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,095,326.00	120,541.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,227,768.00	735,405.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	210,280.00	33,080.04	FEE SCHEDULE LAB	6,421,803.62	699,076.90
EKG/ECG	643,389.00	10,477.00	MRI SERVICES	1,322,096.00	143,994.00
IV THERAPY	2,528,570.00	336,864.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,472,403.21	426,508.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,655.00	10,465.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,233.00	37,422.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,056,518.00	1,701.00	AMBULANCE	0.00	0.00
GI SERVICES	17,918.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,540,066.00	12,246.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,631,516.00	82,283.00	DRUG-SPECIFIC/HOME IV	12,570.00	5,784.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,654,951.00	2,996,041.82
RADIOLOGY THERAPEUTIC	1,512,504.00	640,205.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,207.00	30,205.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,741.00	11,202.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,260.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,316.00	13,662.00	TRAUMA RESPONSE	0.00	38,672.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,638.34	1,090,272.42
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	163.00	0.00
OTHER IMAGING SERVICE	1,671,788.40	89,098.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,734.00	92,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	932,875.00	434,108.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,516,943.00	487,535.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	510,679.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,077,499.00	152,747.00			

TOTAL ANCILLARY	41,034,312.15	9,618,768.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,034,312.15	9,618,768.75

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
626	9818063000904	10/20/17 - 10/20/17	03/12/18	163.00	0.00	0.00	0.00	0.00
-1	2018144059126	05/08/18 - 01/01/00	06/04/18	0.00	0.00	0.00	0.00	0.00
-1	2018144059430	05/17/18 - 01/01/00	06/11/18	0.00	0.00	0.00	0.00	0.00
-1	2018144059430	05/17/18 - 01/01/00	06/11/18	0.00	0.00	0.00	0.00	0.00
TOTAL				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 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	749,049.45	ADJUSTMENTS	0.00
COVERED CHARGES	595,402.19	CONTRACTUAL ALLOW	312,375.12
NON-COVERD CHARGES	153,647.26	TOTAL MEDICAID LIAB	283,027.07
		LESS: COB	282,862.29
		LESS: COPAYMENT	164.78
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 165

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,226.00	13,754.00	OTHER LAB	16,304.00	0.00
MED/SURG SUPPLY	21,259.30	1,016.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,319.00	2,714.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,139.00	10,569.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	553.00	FEE SCHEDULE LAB	96,899.60	15,251.00
EKG/ECG	9,559.00	0.00	MRI SERVICES	24,014.00	10,954.00
IV THERAPY	52,768.00	5,131.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	25,630.50	30,700.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,149.00	1,224.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	311.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,999.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,811.00	558.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,722.00	1,707.00	DRUG-SPECIFIC/HOME IV	2,836.00	1,928.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,824.00	8,682.00
RADIOLOGY THERAPEUTIC	18,806.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	512.00	TRAUMA RESPONSE	0.00	4,618.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,719.79	28,738.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,592.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,356.00	3,682.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,478.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,261.00	2,809.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,715.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,815.00	1,707.00			

TOTAL ANCILLARY	595,402.19	153,647.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	595,402.19	153,647.26

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	611,564.40	ADJUSTMENTS	5,613.03
COVERED CHARGES	587,720.40	CONTRACTUAL ALLOW	561,048.04
NON-COVERD CHARGES	23,844.00	TOTAL MEDICAID LIAB	26,672.36
		LESS: COB	0.00
		LESS: COPAYMENT	507.00
		REIMBURSEMENT	26,165.36
		TOTAL NUMBER OF CLAIMS	460

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.00	3,704.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,244.00	740.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,958.40	7,724.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,059.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,190.00	8,380.00
EKG/ECG	3,366.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,626.00	922.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,373.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,543.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,847.00	2,374.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	6.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,798.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,356.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	225.00	0.00			

TOTAL ANCILLARY	587,720.40	23,844.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	587,720.40	23,844.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,548.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,851.00	CONTRACTUAL ALLOW	8,349.22
NON-COVERD CHARGES	697.00	TOTAL MEDICAID LIAB	6,501.78
		LESS: COB	6,492.78
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	221.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	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	5,052.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,167.00	72.00
EKG/ECG	306.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,378.00	304.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	4,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,445.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,851.00	697.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,851.00	697.00

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 IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,967,995.37	ADJUSTMENTS	254,182.80
COVERED CHARGES	5,840,144.30	CONTRACTUAL ALLOW	4,982,138.00
NON-COVERD CHARGES	1,127,851.07	TOTAL MEDICAID LIAB	858,006.30
		LESS: COB	0.00
		LESS: COPAYMENT	750.74
		REIMBURSEMENT	857,255.56
		TOTAL NUMBER OF CLAIMS	155

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,288.00	97,032.00	OTHER LAB	1,211.00	0.00
MED/SURG SUPPLY	372,150.99	139,832.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	121.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,932.00	15,432.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,138.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,110.00	FEE SCHEDULE LAB	86,244.50	18,294.00
EKG/ECG	11,934.00	306.00	MRI SERVICES	4,267.00	0.00
IV THERAPY	130,546.00	17,084.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,050,007.40	111,881.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,636.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	350,414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,108.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	553,460.00	10,048.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,821,057.00	219,871.00
RADIOLOGY THERAPEUTIC	171,134.00	34,050.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,252.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	85,410.41	433,411.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,630.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	678.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,124.00	869.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	84,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,532.00	24,143.00			

TOTAL ANCILLARY	5,840,144.30	1,127,851.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,840,144.30	1,127,851.07

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,869.05	ADJUSTMENTS	0.00
COVERED CHARGES	44,150.05	CONTRACTUAL ALLOW	21,326.14
NON-COVERD CHARGES	2,719.00	TOTAL MEDICAID LIAB	22,823.91
		LESS: COB	22,820.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.00	2,443.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,359.45	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	947.60	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	21,839.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,787.00	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	8,405.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	497.00	276.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	44,150.05	2,719.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,150.05	2,719.00

** 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,391,395.98	ADJUSTMENTS	1,099,251.01
COVERED CHARGES	22,901,864.95	CONTRACTUAL ALLOW	18,085,453.63
NON-COVERD CHARGES	489,531.03	TOTAL MEDICAID LIAB	4,816,411.32
		LESS: COB	39,460.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,776,950.73

TOTAL NUMBER OF ADMISSIONS 389

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,337	0	1,487,904.00	181,436.00
ROUTINE NURSERY	217	0	245,279.00	17,198.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,554	0	1,733,183.00	198,634.00
SPECIAL CARE SERVICES				
CCU	62	0	141,780.00	0.00
ICU	498	0	1,248,150.00	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	560	0	1,389,930.00	0.00
TOTAL ACCOMODATIONS	2,114	0	3,123,113.00	198,634.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,260,116.11	7,228.00	OTHER LAB	100,990.00	0.00
MED/SURG SUPPLY	1,859,595.18	16,140.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,906,608.80	7,283.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167,205.00	0.00	OTHER THERAPEUTIC SVC	23,825.00	0.00
CT SCAN	1,134,330.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	145,332.00	160.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	125,510.00	0.00	MRI SERVICES	282,717.00	0.00
IV THERAPY	441,310.00	1,208.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,542,644.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	69,978.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,605,750.00	1,487.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	534,755.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	472,133.00	1,325.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	410,849.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,418.00
LABORATORY PATHOLOGIC	81,130.20	0.00	INJECTABLE DRUGS	32,539.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	53,938.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,278.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	192,720.00	59,532.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,407.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	791,443.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,974.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,156.00	122,846.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,052.00	12,421.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	813,871.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,846.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	326,749.00	59,849.00			

TOTAL ANCILLARY	19,778,751.95	290,897.03
TOTAL ACCOMODATIONS	3,123,113.00	198,634.00
TOTAL CHARGES	22,901,864.95	489,531.03

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	425,160.09	ADJUSTMENTS	0.00
COVERED CHARGES	404,775.09	CONTRACTUAL ALLOW	179,073.52
NON-COVERD CHARGES	20,385.00	TOTAL MEDICAID LIAB	225,701.57
		LESS: COB	225,701.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	19

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	43,226.00	16,483.00
ROUTINE NURSERY	12	0	14,097.00	1,244.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	51	0	57,323.00	17,727.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	5,130.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	5,130.00	0.00
TOTAL ACCOMODATIONS	53	0	62,453.00	17,727.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,019.00	0.00	OTHER LAB	6,900.00	0.00
MED/SURG SUPPLY	32,593.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,907.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,472.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,255.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	666.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	3,390.00	0.00
IV THERAPY	5,541.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,748.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,240.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,015.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,672.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,818.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,463.20	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	226.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,239.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,809.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,707.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,521.00	2,658.00			

TOTAL ANCILLARY	342,322.09	2,658.00
TOTAL ACCOMODATIONS	62,453.00	17,727.00
TOTAL CHARGES	404,775.09	20,385.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,044,683.04	ADJUSTMENTS	329,299.12
COVERED CHARGES	10,989,330.99	CONTRACTUAL ALLOW	9,450,025.33
NON-COVERD CHARGES	2,055,352.05	TOTAL MEDICAID LIAB	1,539,305.66
		LESS: COB	1,872.69
		LESS: COPAYMENT	2,947.98
		REIMBURSEMENT	1,534,484.99
		ALL OTHER	1,389,785.48
		FEE SCHEDULE-LAB	106,677.48
		INJECTABLE DRUGS	38,022.03

TOTAL NUMBER OF CLAIMS 2,519

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,807.48	142,579.00	OTHER LAB	187,055.00	954.00
MED/SURG SUPPLY	292,620.54	103,569.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	363,414.00	36,532.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,751,978.00	152,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,445.00	2,145.02	FEE SCHEDULE LAB	1,446,366.50	194,236.30
EKG/ECG	189,094.00	2,448.00	MRI SERVICES	392,852.00	33,516.00
IV THERAPY	743,001.00	92,012.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,151,071.33	223,181.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,142.00	1,623.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,780.00	3,704.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	297,080.00	972.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,722,882.00	2,835.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	501,724.00	15,619.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	608,256.40	213,615.00
RADIOLOGY THERAPEUTIC	262,571.00	309,752.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	389.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	337.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,921.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,457.74	235,577.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	230,945.00	22,511.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,372.00	16,569.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	165,122.00	83,638.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	330,912.00	143,299.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	77,426.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	127,956.00	19,617.00			

TOTAL ANCILLARY	10,989,330.99	2,055,352.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,989,330.99	2,055,352.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,381.52	ADJUSTMENTS	0.00
COVERED CHARGES	202,890.52	CONTRACTUAL ALLOW	93,937.25
NON-COVERD CHARGES	49,491.00	TOTAL MEDICAID LIAB	108,953.27
		LESS: COB	108,931.76
		LESS: COPAYMENT	21.51
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,188.00	6,872.00	OTHER LAB	4,277.00	0.00
MED/SURG SUPPLY	4,162.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,583.00	2,610.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,018.00	7,307.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,407.00	3,787.00
EKG/ECG	1,530.00	0.00	MRI SERVICES	9,593.00	3,093.00
IV THERAPY	17,549.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,423.00	15,294.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	306.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,313.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,387.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,414.00	3,281.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,252.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,628.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,809.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	202,890.52	49,491.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	202,890.52	49,491.00

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 INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	595,574.00	ADJUSTMENTS	2,870.52
COVERED CHARGES	544,636.00	CONTRACTUAL ALLOW	531,691.40
NON-COVERD CHARGES	50,938.00	TOTAL MEDICAID LIAB	12,944.60
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	12,611.60

TOTAL NUMBER OF CLAIMS 223

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252.00	8,848.00	OTHER LAB	4,059.00	0.00
MED/SURG SUPPLY	104.00	185.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,910.00	6,155.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,758.00	14,614.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	90,923.00	9,199.00
EKG/ECG	9,792.00	0.00	MRI SERVICES	3,040.00	3,018.00
IV THERAPY	41,494.00	3,486.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	226,280.00	558.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,307.00	3,430.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,039.00	1,445.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	544,636.00	50,938.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	544,636.00	50,938.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,169.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,795.00	CONTRACTUAL ALLOW	17,665.14
NON-COVERD CHARGES	6,374.00	TOTAL MEDICAID LIAB	8,129.86
		LESS: COB	8,120.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,105.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	463.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,375.00	499.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,052.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,262.00	72.00
EKG/ECG	0.00	0.00	MRI SERVICES	5,277.00	0.00
IV THERAPY	5,591.00	4,256.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,204.00	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	571.00	442.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,795.00	6,374.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,795.00	6,374.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,434,322.31	ADJUSTMENTS	62,375.88
COVERED CHARGES	1,218,883.33	CONTRACTUAL ALLOW	1,067,908.64
NON-COVERD CHARGES	215,438.98	TOTAL MEDICAID LIAB	150,974.69
		LESS: COB	0.00
		LESS: COPAYMENT	109.51
		REIMBURSEMENT	150,865.18

TOTAL NUMBER OF CLAIMS 29

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,532.00	21,546.00	OTHER LAB	1,211.00	0.00
MED/SURG SUPPLY	209,491.44	11,313.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,721.00	4,345.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,558.00	6,059.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,293.50	7,803.40
EKG/ECG	5,814.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	40,148.00	6,384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	467,060.50	7,026.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	154,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,191.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,419.00	7,082.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,505.00	20,961.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,906.89	107,889.82
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,445.00	1,239.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	762.00	1,841.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,809.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,200.00	11,949.00			

TOTAL ANCILLARY	1,218,883.33	215,438.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,218,883.33	215,438.98

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,946,501.02	ADJUSTMENTS	701,592.36
COVERED CHARGES	35,538,022.00	CONTRACTUAL ALLOW	27,775,288.38
NON-COVERD CHARGES	408,479.02	TOTAL MEDICAID LIAB	7,762,733.62
		LESS: COB	60,632.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,702,100.67

TOTAL NUMBER OF ADMISSIONS 1,226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,219	0	4,292,990.00	69,192.00
ROUTINE NURSERY	814	0	1,233,770.00	121,680.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,033	0	5,526,760.00	190,872.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	480	0	1,562,930.00	0.00
NICU	291	0	1,505,362.50	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	771	0	3,068,292.50	0.00
TOTAL ACCOMODATIONS	4,804	0	8,595,052.50	190,872.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,241,317.31	1,512.15	OTHER LAB	128,434.00	0.00
MED/SURG SUPPLY	1,518,749.51	18,720.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,422,699.03	12,168.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	674,764.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,458,055.00	26,432.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	157,663.56	2,040.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	334,734.00	0.00	MRI SERVICES	566,978.00	0.00
IV THERAPY	466,547.00	3,875.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,060,288.50	12,624.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,603,871.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,951,280.11	5,013.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	156,482.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,213,916.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	277,757.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	105,102.20	0.00	INJECTABLE DRUGS	390,246.46	0.00
RADIOLOGY THERAPEUTIC	36,789.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,697.33	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,988.12	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	85,695.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,298.00	822.00	TRAUMA RESPONSE	0.00	28,112.00
PSYCHIATRIC SERVICES	281,103.00	3,535.00	IMPL DEV CHARGE PATIENTS	663,759.37	0.00
LITHOTRIPSY	28,504.00	0.00	NO CC/INVALID REV CODE	0.00	64,180.00
OTHER IMAGING SERVICE	230,857.00	0.00			
BLOOD	83,097.00	0.00			
BLOOD STORAGE & PRO.	115,525.50	38,216.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	202,249.00	0.00			
AUDIOLOGY	140,999.00	0.00			
CARDIOLOGY	1,186,704.50	357.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,186.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,633.00	0.00			

TOTAL ANCILLARY	26,942,969.50	217,607.02
TOTAL ACCOMODATIONS	8,595,052.50	190,872.00
TOTAL CHARGES	35,538,022.00	408,479.02

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 10/01/17 THROUGH 09/30/18
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	2017334000407	11/21/17 - 11/23/17	12/04/17	0.00	6,269.00	0.00	0.00	0.00
614	2018046066442	02/01/18 - 02/09/18	02/19/18	0.00	2,064.00	0.00	0.00	0.00
614	2018058000526	02/09/18 - 02/17/18	03/05/18	0.00	15,981.00	0.00	0.00	0.00
614	2018082076363	02/20/18 - 02/28/18	03/26/18	0.00	6,027.00	0.00	0.00	0.00
614	2218099008156	01/20/18 - 01/25/18	04/16/18	0.00	6,269.00	0.00	0.00	0.00
614	2018117018630	04/10/18 - 04/18/18	04/30/18	0.00	6,894.00	0.00	0.00	0.00
614	2018138020620	01/26/18 - 02/05/18	05/21/18	0.00	12,585.00	0.00	0.00	0.00
614	2018159012202	05/23/18 - 05/24/18	06/11/18	0.00	2,064.00	0.00	0.00	0.00
614	2019060000486	06/11/18 - 06/13/18	03/04/19	0.00	6,027.00	0.00	1,314.64	0.00
TOTAL				0.00	64,180.00	0.00	1,314.64	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	322,656.45	ADJUSTMENTS	0.00
COVERED CHARGES	312,916.45	CONTRACTUAL ALLOW	138,656.50
NON-COVERD CHARGES	9,740.00	TOTAL MEDICAID LIAB	174,259.95
		LESS: COB	174,259.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	54	0	72,022.00	2,846.00
ROUTINE NURSERY	14	0	13,360.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	68	0	85,382.00	2,846.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1	0	4,435.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,435.00	0.00
TOTAL ACCOMODATIONS	69	0	89,817.00	2,846.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,525.08	0.00	OTHER LAB	3,909.00	0.00
MED/SURG SUPPLY	9,050.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,597.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,354.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,248.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,291.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,184.00	0.00	MRI SERVICES	6,069.00	0.00
IV THERAPY	3,306.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,452.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,073.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,518.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,328.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,016.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	145.00	0.00	INJECTABLE DRUGS	972.70	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	297.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	15,574.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,894.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,688.00	0.00			
CARDIOLOGY	5,502.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	223,099.45	6,894.00
TOTAL ACCOMODATIONS	89,817.00	2,846.00
TOTAL CHARGES	312,916.45	9,740.00

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 10/01/17 THROUGH 09/30/18
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	2018229041948	03/20/18 - 03/23/18	08/20/18	0.00	6,894.00	0.00	23,112.11	0.00
TOTAL				0.00	6,894.00	0.00	23,112.11	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,997,376.08	ADJUSTMENTS	867,133.86
COVERED CHARGES	28,624,619.67	CONTRACTUAL ALLOW	24,783,748.26
NON-COVERD CHARGES	1,372,756.41	TOTAL MEDICAID LIAB	3,840,871.41
		LESS: COB	1,790.97
		LESS: COPAYMENT	7,936.83
		REIMBURSEMENT	3,831,143.61
		ALL OTHER	3,134,570.04
		FEE SCHEDULE-LAB	383,082.11
		INJECTABLE DRUGS	313,491.46

TOTAL NUMBER OF CLAIMS 8,776

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	553,797.56	2,539.40	OTHER LAB	732,397.00	1,915.00
MED/SURG SUPPLY	781,037.37	5,181.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	10,546.00	268.00
RADIOLOGY-DIAGNOSTIC	1,432,002.00	28,527.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,213,375.00	184,253.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,103.00	16,067.12	FEE SCHEDULE LAB	6,827,152.46	279,491.28
EKG/ECG	510,288.00	5,652.00	MRI SERVICES	998,852.00	67,548.00
IV THERAPY	1,524,662.00	170,919.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,567,230.87	118,483.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,988.00	1,004.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	359,175.00	51,231.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	172,112.00	1,656.00	AMBULANCE	0.00	0.00
GI SERVICES	8,273.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,710,990.50	2,837.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	150,112.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,182,775.55	55,325.05
RADIOLOGY THERAPEUTIC	498,013.00	26,906.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,129.00	5,081.24	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,980.00	1,719.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,038.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,835.00	1,480.00	TRAUMA RESPONSE	0.00	96,850.00
PSYCHIATRIC SERVICES	1,399.00	14,070.00	IMPL DEV CHARGE PATIENTS	72,565.36	0.00
LITHOTRIPSY	109,814.00	0.00	NO CC/INVALID REV CODE	0.00	4,280.00
OTHER IMAGING SERVICE	744,331.00	122,679.00			
BLOOD	135,818.00	1,612.00			
BLOOD STORAGE & PRO.	82,844.00	3,836.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	465,073.00	28,007.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	849,719.00	46,129.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	141,714.00	3,088.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	680,516.00	20,083.00			

TOTAL ANCILLARY	28,624,619.67	1,372,756.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,624,619.67	1,372,756.41

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 10/01/17 THROUGH 09/30/18
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	5918319004697	08/31/18 - 08/31/18	11/19/18	0.00	2,174.00	0.00	0.00	0.00
615	5918319004697	08/31/18 - 08/31/18	11/19/18	0.00	2,106.00	0.00	0.00	0.00
TOTAL				0.00	4,280.00	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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	658,139.45	ADJUSTMENTS	0.00
COVERED CHARGES	572,194.95	CONTRACTUAL ALLOW	274,292.00
NON-COVERD CHARGES	85,944.50	TOTAL MEDICAID LIAB	297,902.95
		LESS: COB	297,762.49
		LESS: COPAYMENT	140.46
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 153

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,328.88	0.00	OTHER LAB	6,118.00	0.00
MED/SURG SUPPLY	43,321.59	238.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	308.00	0.00
RADIOLOGY-DIAGNOSTIC	28,865.00	1,287.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,626.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	475.00	0.00	FEE SCHEDULE LAB	98,118.57	5,413.50
EKG/ECG	5,990.00	0.00	MRI SERVICES	24,445.00	0.00
IV THERAPY	25,352.00	3,286.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	68,029.00	42,587.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,450.00	1,562.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,397.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,606.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,199.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,722.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,339.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	278.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,801.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,172.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,284.00	21,620.00			
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	15,265.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,634.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,070.00	7,662.00			

TOTAL ANCILLARY	572,194.95	85,944.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	572,194.95	85,944.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	220,577.67	ADJUSTMENTS	1,856.20
COVERED CHARGES	216,054.67	CONTRACTUAL ALLOW	205,817.56
NON-COVERD CHARGES	4,523.00	TOTAL MEDICAID LIAB	10,237.11
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	9,964.11

TOTAL NUMBER OF CLAIMS 174

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,996.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,308.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,009.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,760.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	241.00	0.00	FEE SCHEDULE LAB	44,818.00	2,234.00
EKG/ECG	5,034.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,204.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	135,057.00	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	164.30	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	94.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,528.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	216,054.67	4,523.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	216,054.67	4,523.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,590.34	ADJUSTMENTS	0.00
COVERED CHARGES	24,072.34	CONTRACTUAL ALLOW	12,709.90
NON-COVERD CHARGES	518.00	TOTAL MEDICAID LIAB	11,362.44
		LESS: COB	11,359.44
		LESS: COPAYMENT	3.00
		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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	282.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,118.00	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	4,577.00	518.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	778.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,096.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,091.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,072.34	518.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,072.34	518.00

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,372,969.58	ADJUSTMENTS	138,399.75
COVERED CHARGES	5,163,696.55	CONTRACTUAL ALLOW	4,686,806.77
NON-COVERD CHARGES	209,273.03	TOTAL MEDICAID LIAB	476,889.78
		LESS: COB	0.00
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	476,220.78
		TOTAL NUMBER OF CLAIMS	86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,031.96	7,554.45	OTHER LAB	5,440.00	0.00
MED/SURG SUPPLY	127,224.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,640.00	26,440.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,067.00	7,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	278.00	475.00	FEE SCHEDULE LAB	125,618.68	11,695.12
EKG/ECG	10,944.00	1,174.00	MRI SERVICES	33,051.00	2,174.00
IV THERAPY	142,950.00	4,710.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	732,650.00	17,031.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,834.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,247.00	563.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,555.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,687,516.03	48,953.46
RADIOLOGY THERAPEUTIC	356,974.00	8,896.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	495.00	495.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	203.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	250,493.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	562.00	0.00			
BLOOD	19,480.00	0.00			
BLOOD STORAGE & PRO.	5,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,001.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	479,555.00	71,054.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,088.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,488.00	235.00			

TOTAL ANCILLARY	5,163,696.55	209,273.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,163,696.55	209,273.03

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	436,441.71	ADJUSTMENTS	0.00
COVERED CHARGES	436,441.71	CONTRACTUAL ALLOW	297,821.94
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	138,619.77
		LESS: COB	6,179.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	132,440.43

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	56	0	71,788.00	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	56	0	71,788.00	0.00
SPECIAL CARE SERVICES				
CCU	29	0	55,941.00	0.00
ICU	2	0	5,952.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	31	0	61,893.00	0.00
TOTAL ACCOMODATIONS	87	0	133,681.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,413.95	0.00	OTHER LAB	1,174.00	0.00
MED/SURG SUPPLY	7,055.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	72,524.00	0.00	EDUCATION & TRAINING	920.00	0.00
RADIOLOGY-DIAGNOSTIC	9,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,551.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,280.21	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,994.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,399.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,578.28	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	14,144.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	490.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	742.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,995.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,655.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	796.00	0.00			

TOTAL ANCILLARY	302,760.71	0.00
TOTAL ACCOMODATIONS	133,681.00	0.00
TOTAL CHARGES	436,441.71	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSPITAL
200 ALLEN MEMORIAL DR
BREMEN,GA 30110-2012

PROVIDER NUMBER
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,018,605.08	ADJUSTMENTS	140,066.85
COVERED CHARGES	3,911,047.91	CONTRACTUAL ALLOW	3,178,005.79
NON-COVERD CHARGES	107,557.17	TOTAL MEDICAID LIAB	733,042.12
		LESS: COB	1,599.14
		LESS: COPAYMENT	2,106.00
		REIMBURSEMENT	729,336.98
		ALL OTHER	674,975.59
		FEE SCHEDULE-LAB	45,855.57
		INJECTABLE DRUGS	8,505.82

TOTAL NUMBER OF CLAIMS 1,660

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,148.22	0.00	OTHER LAB	23,823.00	0.00
MED/SURG SUPPLY	21,645.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	180.00
RADIOLOGY-DIAGNOSTIC	223,235.00	4,138.00	OTHER THERAPEUTIC SVC	0.00	462.00
CT SCAN	624,078.00	36,168.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	111,508.00	1,465.00	FEE SCHEDULE LAB	518,847.00	10,601.00
EKG/ECG	49,224.00	538.00	MRI SERVICES	248,362.00	11,040.00
IV THERAPY	246,952.00	19,343.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	285,134.80	4,363.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,229.00	1,578.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,130.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,021.00	2,889.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	939,592.28	1,154.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,631.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	63,899.23	8,833.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,451.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,196.00	0.00
LITHOTRIPSY	57,611.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,456.00	2,290.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,196.00	436.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,455.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,070.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,604.00	627.00			

TOTAL ANCILLARY	3,911,047.91	107,557.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,911,047.91	107,557.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	80,272.71	ADJUSTMENTS	0.00
COVERED CHARGES	55,557.57	CONTRACTUAL ALLOW	14,546.95
NON-COVERD CHARGES	24,715.14	TOTAL MEDICAID LIAB	41,010.62
		LESS: COB	41,001.62
		LESS: COPAYMENT	9.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,860.61	23.51	OTHER LAB	806.00	0.00
MED/SURG SUPPLY	220.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,920.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,165.00	14,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,651.00	982.00
EKG/ECG	538.00	0.00	MRI SERVICES	7,969.00	0.00
IV THERAPY	4,390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,226.00	5,226.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	162.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,534.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,398.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	232.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	930.00	138.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	3,395.63
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,117.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,557.57	24,715.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,557.57	24,715.14

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,275.01	ADJUSTMENTS	432.00
COVERED CHARGES	177,552.01	CONTRACTUAL ALLOW	170,602.01
NON-COVERD CHARGES	5,723.00	TOTAL MEDICAID LIAB	6,950.00
		LESS: COB	39.75
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	6,700.25
		TOTAL NUMBER OF CLAIMS	139

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,499.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	635.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,398.00	363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,797.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,711.00	601.00
EKG/ECG	2,690.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,674.00	167.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	100,786.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,560.13	42.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,552.01	5,723.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,552.01	5,723.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,412.24	ADJUSTMENTS	0.00
COVERED CHARGES	3,840.24	CONTRACTUAL ALLOW	531.58
NON-COVERD CHARGES	4,572.00	TOTAL MEDICAID LIAB	3,308.66
		LESS: COB	3,305.66
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,370.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	391.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,629.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	375.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,840.24	4,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,840.24	4,572.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,083,076.87	ADJUSTMENTS	525,997.44
COVERED CHARGES	23,351,852.94	CONTRACTUAL ALLOW	14,856,028.76
NON-COVERD CHARGES	1,731,223.93	TOTAL MEDICAID LIAB	8,495,824.18
		LESS: COB	49,130.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,446,693.72

TOTAL NUMBER OF ADMISSIONS 1,158

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,520	0	4,636,516.00	1,637,144.00
ROUTINE NURSERY	403	0	410,851.00	31,799.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,923	0	5,047,367.00	1,668,943.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	966	0	1,903,088.00	0.00
NICU	30	0	112,500.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	996	0	2,015,588.00	0.00
TOTAL ACCOMODATIONS	5,919	0	7,062,955.00	1,668,943.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,214,627.64	21.11	OTHER LAB	78,057.90	0.00
MED/SURG SUPPLY	374,102.28	94.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,685,006.05	99.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390,415.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	457,750.00	10,698.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	311,116.98	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	353,130.00	0.00	MRI SERVICES	107,000.00	0.00
IV THERAPY	19,068.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,485,701.46	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	712,747.50	5,959.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,619,073.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	317,250.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,888,736.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,298.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	57,478.35	0.00	INJECTABLE DRUGS	281.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	62,014.86	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	258,153.00	12,616.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,249.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,484.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,072.00
OTHER IMAGING SERVICE	100,247.58	14,000.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	138,425.18	720.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,672.55	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	791,865.72	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,417.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	191,528.30	0.00			

TOTAL ANCILLARY	16,288,897.94	62,280.93
TOTAL ACCOMODATIONS	7,062,955.00	1,668,943.00
TOTAL CHARGES	23,351,852.94	1,731,223.93

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 01/01/18 THROUGH 12/31/18
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	2018037064943	01/18/18 - 02/01/18	02/12/18	0.00	1,000.00	0.00	0.00	0.00
615	2018094045971	03/24/18 - 03/29/18	04/09/18	0.00	1,000.00	0.00	0.00	0.00
616	2018136022644	05/04/18 - 05/08/18	05/21/18	0.00	1,000.00	0.00	0.00	0.00
615	2018138076109	03/25/18 - 04/06/18	05/21/18	0.00	1,000.00	0.00	0.00	0.00
615	2018162020011	06/01/18 - 06/03/18	06/18/18	0.00	1,000.00	0.00	0.00	0.00
615	2018184073701	03/22/18 - 03/23/18	07/09/18	0.00	1,000.00	0.00	0.00	0.00
615	2018187057452	06/16/18 - 06/30/18	07/09/18	0.00	1,000.00	0.00	0.00	0.00
615	5918213000012	01/09/18 - 02/14/18	08/06/18	0.00	1,000.00	0.00	0.00	0.00
615	2318214000148	04/25/18 - 04/28/18	09/03/18	0.00	1,000.00	0.00	653.57	0.00
615	2018218024822	07/29/18 - 07/31/18	08/13/18	0.00	1,000.00	0.00	0.00	0.00
615	2218262010057	08/16/18 - 08/20/18	09/24/18	0.00	1,000.00	0.00	0.00	0.00
615	2018289077106	10/08/18 - 10/10/18	10/22/18	0.00	1,000.00	0.00	0.00	0.00
948	2018305096304	10/15/18 - 10/21/18	11/05/18	0.00	72.00	0.00	0.00	0.00
615	2018337028675	07/24/18 - 08/03/18	12/10/18	0.00	1,000.00	0.00	0.00	0.00
615	2019002055198	12/19/18 - 12/22/18	01/07/19	0.00	1,000.00	0.00	0.00	0.00
615	2019009048016	12/27/18 - 12/30/18	01/14/19	0.00	1,000.00	0.00	0.00	0.00
615	5919057001157	11/20/18 - 12/05/18	03/04/19	0.00	1,000.00	0.00	0.00	0.00
615	2019171072508	01/24/18 - 01/26/18	06/24/19	0.00	1,000.00	0.00	0.00	0.00
615	5919227001468	04/12/18 - 04/13/18	08/19/19	0.00	1,000.00	0.00	0.00	0.00
TOTAL				0.00	18,072.00	0.00	653.57	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	218,675.31	ADJUSTMENTS	0.00
COVERED CHARGES	208,257.31	CONTRACTUAL ALLOW	77,086.13
NON-COVERD CHARGES	10,418.00	TOTAL MEDICAID LIAB	131,171.18
		LESS: COB	131,171.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	51	0	50,509.00	9,671.00
ROUTINE NURSERY	6	0	5,850.00	450.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	57	0	56,359.00	10,121.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	9,800.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	9,800.00	0.00
TOTAL ACCOMODATIONS	64	0	66,159.00	10,121.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,423.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,092.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,684.41	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,364.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,980.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	561.00	0.00	PROFESSIONAL FEES	0.00	297.00
OPERATING ROOM	18,828.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,221.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,522.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,212.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	125.30	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	555.21	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	998.52	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,368.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,391.50	0.00			

TOTAL ANCILLARY	142,098.31	297.00
TOTAL ACCOMODATIONS	66,159.00	10,121.00
TOTAL CHARGES	208,257.31	10,418.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,829,434.65	ADJUSTMENTS	476,803.69
COVERED CHARGES	14,341,523.30	CONTRACTUAL ALLOW	11,142,299.68
NON-COVERD CHARGES	1,487,911.35	TOTAL MEDICAID LIAB	3,199,223.62
		LESS: COB	11,721.43
		LESS: COPAYMENT	8,326.44
		REIMBURSEMENT	3,179,175.75
		ALL OTHER	2,746,206.30
		FEE SCHEDULE-LAB	297,783.20
		INJECTABLE DRUGS	135,186.25

TOTAL NUMBER OF CLAIMS 6,402

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,741.55	14,809.90	OTHER LAB	304,459.04	1,020.21
MED/SURG SUPPLY	156,277.85	81,492.56	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,855.00	0.00
RADIOLOGY-DIAGNOSTIC	527,479.95	28,083.02	OTHER THERAPEUTIC SVC	0.00	567.90
CT SCAN	671,165.00	65,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,242.72	31,395.39	FEE SCHEDULE LAB	1,154,775.07	131,326.38
EKG/ECG	430,935.00	5,364.00	MRI SERVICES	89,000.00	4,000.00
IV THERAPY	297,456.00	64,393.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,506,357.47	453,489.31	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,932.00	0.00	REHAB THERAPY	0.00	3,120.00
RESPIRATORY SERVICES	112,465.50	39,747.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	162,900.00	2,250.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,602,142.37	36,131.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	306,828.00	1,188.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294,409.36	241,043.05
RADIOLOGY THERAPEUTIC	22,674.80	280.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	57,617.88	10,343.94	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,378.86	2,144.37	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,262.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,763.00	7,768.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,869.72	425.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	333,431.09	29,426.64			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,171.29	12,061.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,695.68	13,483.92			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	561,045.48	181,793.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,950.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	406,503.12	749.00			

TOTAL ANCILLARY	14,341,523.30	1,487,911.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,341,523.30	1,487,911.35

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	291,423.57	ADJUSTMENTS	0.00
COVERED CHARGES	226,097.72	CONTRACTUAL ALLOW	117,714.37
NON-COVERD CHARGES	65,325.85	TOTAL MEDICAID LIAB	108,383.35
		LESS: COB	108,278.40
		LESS: COPAYMENT	104.95
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 130

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,218.37	901.06	OTHER LAB	2,373.26	0.00
MED/SURG SUPPLY	1,216.36	1,477.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,904.58	2,708.80	OTHER THERAPEUTIC SVC	0.00	99.60
CT SCAN	7,500.00	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	242.52	115.89	FEE SCHEDULE LAB	14,892.75	1,718.30
EKG/ECG	5,364.00	298.00	MRI SERVICES	0.00	4,000.00
IV THERAPY	1,296.00	0.00	PROFESSIONAL FEES	0.00	178.20
OPERATING ROOM	24,921.40	33,638.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,729.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	426.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,042.50	553.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,820.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,705.93	686.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	199.80	254.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,382.00	186.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22.63	425.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,331.36	7,998.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,897.26	2,160.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	388.00	0.00			

TOTAL ANCILLARY	226,097.72	65,325.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	226,097.72	65,325.85

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	344,246.17	ADJUSTMENTS	5,448.78
COVERED CHARGES	336,330.94	CONTRACTUAL ALLOW	322,233.83
NON-COVERD CHARGES	7,915.23	TOTAL MEDICAID LIAB	14,097.11
		LESS: COB	0.00
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	13,797.11
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	539.74	0.00	OTHER LAB	687.37	0.00
MED/SURG SUPPLY	14.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,596.00	1,392.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,500.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,338.75	3,746.13
EKG/ECG	3,874.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,822.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	271,967.50	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	4,580.40	934.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	93.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,410.22	998.52			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	336,330.94	7,915.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	336,330.94	7,915.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,267.60	ADJUSTMENTS	0.00
COVERED CHARGES	7,081.41	CONTRACTUAL ALLOW	3,948.06
NON-COVERD CHARGES	186.19	TOTAL MEDICAID LIAB	3,133.35
		LESS: COB	3,124.35
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	506.94	174.10	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	253.74	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	6,222.00	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	98.73	3.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,081.41	186.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,081.41	186.19

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,242,029.25	ADJUSTMENTS	22,168.92
COVERED CHARGES	1,099,535.95	CONTRACTUAL ALLOW	888,817.21
NON-COVERD CHARGES	142,493.30	TOTAL MEDICAID LIAB	210,718.74
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	210,463.74

TOTAL NUMBER OF CLAIMS 38

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,222.85	260.10	OTHER LAB	1,353.05	0.00
MED/SURG SUPPLY	60,339.26	1,647.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,770.40	2,060.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,500.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,797.93	FEE SCHEDULE LAB	16,040.60	7,072.39
EKG/ECG	12,814.00	894.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,056.50	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	423,038.04	56,370.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,344.50	900.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,760.00	184.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,922.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80,832.74	18,683.04
RADIOLOGY THERAPEUTIC	2,425.20	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	187.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,665.98	22,589.55
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	551.50	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,269.94	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,333.39	23,166.95			
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	34,646.00	0.00			

TOTAL ANCILLARY	1,099,535.95	142,493.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,099,535.95	142,493.30

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,235,266.68	ADJUSTMENTS	81,351.85
COVERED CHARGES	1,180,655.71	CONTRACTUAL ALLOW	688,565.61
NON-COVERD CHARGES	54,610.97	TOTAL MEDICAID LIAB	492,090.10
		LESS: COB	805.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	491,284.56

TOTAL NUMBER OF ADMISSIONS 131

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	233	0	124,100.00	24,470.00
ROUTINE NURSERY	112	0	59,875.00	13,558.20
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	345	0	183,975.00	38,028.20
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	345	0	183,975.00	38,028.20

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125,869.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97,857.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	108,018.42	0.00	EDUCATION & TRAINING	987.27	0.00
RADIOLOGY-DIAGNOSTIC	10,962.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,500.14	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,667.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,794.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	315,396.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	127,194.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,093.95	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,293.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,321.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,890.74	0.00	INJECTABLE DRUGS	59,000.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	120.00
OTHER IMAGING SERVICE	10,126.71	0.00			
BLOOD	0.00	8,760.57			
BLOOD STORAGE & PRO.	0.00	4,139.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	3,440.40			
CARDIOLOGY	5,455.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	250.91	122.40			

TOTAL ANCILLARY	996,680.71	16,582.77
TOTAL ACCOMODATIONS	183,975.00	38,028.20
TOTAL CHARGES	1,180,655.71	54,610.97

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 12/01/17 THROUGH 11/30/18
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	2318159000147	02/15/18 - 02/18/18	07/02/18	0.00	120.00	0.00	0.00	0.00
TOTAL				0.00	120.00	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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,636.01	ADJUSTMENTS	0.00
COVERED CHARGES	2,692.81	CONTRACTUAL ALLOW	365.76
NON-COVERD CHARGES	943.20	TOTAL MEDICAID LIAB	2,327.05
		LESS: COB	2,327.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	3	0	1,575.00	870.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,575.00	870.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,575.00	870.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	444.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	399.21	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	66.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	73.20			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,117.81	73.20
TOTAL ACCOMODATIONS	1,575.00	870.00
TOTAL CHARGES	2,692.81	943.20

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,133,541.32	ADJUSTMENTS	36,261.64
COVERED CHARGES	2,060,139.13	CONTRACTUAL ALLOW	1,683,291.31
NON-COVERD CHARGES	73,402.19	TOTAL MEDICAID LIAB	376,847.82
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	376,283.82
		ALL OTHER	316,036.47
		FEE SCHEDULE-LAB	58,258.39
		INJECTABLE DRUGS	1,988.96

TOTAL NUMBER OF CLAIMS 801

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,996.53	0.00	OTHER LAB	4,507.70	0.00
MED/SURG SUPPLY	43,078.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	107.68	EDUCATION & TRAINING	0.00	1,794.08
RADIOLOGY-DIAGNOSTIC	79,939.75	622.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	82,965.79	21,946.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	376,014.62	12,630.21
EKG/ECG	30,340.80	240.00	MRI SERVICES	0.00	0.00
IV THERAPY	51,963.27	5,062.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	749,492.26	2,701.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,263.08	8,435.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	59,262.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	228,821.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,714.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,349.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,151.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,007.50	7,765.17			
BLOOD	0.00	3,288.52			
BLOOD STORAGE & PRO.	0.00	2,035.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,767.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,654.23	3,470.58			

TOTAL ANCILLARY	2,060,139.13	73,402.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,060,139.13	73,402.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	99,488.95	ADJUSTMENTS	0.00
COVERED CHARGES	91,185.16	CONTRACTUAL ALLOW	53,519.44
NON-COVERD CHARGES	8,303.79	TOTAL MEDICAID LIAB	37,665.72
		LESS: COB	37,653.72
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,509.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,312.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	147.25	EDUCATION & TRAINING	0.00	90.23
RADIOLOGY-DIAGNOSTIC	311.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,226.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,773.54	740.87
EKG/ECG	247.20	247.20	MRI SERVICES	0.00	0.00
IV THERAPY	4,825.40	1,888.63	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,304.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	266.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,005.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,753.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	400.30	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	84.05	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,036.86	2,521.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,337.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,099.53	1,358.00			

TOTAL ANCILLARY	91,185.16	8,303.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,185.16	8,303.79

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	83,013.95	ADJUSTMENTS	2,996.66
COVERED CHARGES	79,677.34	CONTRACTUAL ALLOW	74,396.44
NON-COVERD CHARGES	3,336.61	TOTAL MEDICAID LIAB	5,280.90
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	5,151.90
		TOTAL NUMBER OF CLAIMS	78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,200.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	555.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,252.63	934.41	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,800.39	1,485.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,867.61	796.60
EKG/ECG	494.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	751.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,196.02	120.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,517.88	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	520.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	515.41	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,004.64	0.00			

TOTAL ANCILLARY	79,677.34	3,336.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,677.34	3,336.61

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,078.87	ADJUSTMENTS	0.00
COVERED CHARGES	3,065.60	CONTRACTUAL ALLOW	1,951.91
NON-COVERD CHARGES	13.27	TOTAL MEDICAID LIAB	1,113.69
		LESS: COB	1,110.69
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.47	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	690.55	13.27
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	133.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,502.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	333.72	0.00			

TOTAL ANCILLARY	3,065.60	13.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,065.60	13.27

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,814.09	ADJUSTMENTS	5,751.49
COVERED CHARGES	27,800.82	CONTRACTUAL ALLOW	22,046.33
NON-COVERD CHARGES	13.27	TOTAL MEDICAID LIAB	5,754.49
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,751.49

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,441.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,247.58	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	904.24	13.27
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	21,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	688.45	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	27,800.82	13.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,800.82	13.27

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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	309,765.23	ADJUSTMENTS	14,089.17
COVERED CHARGES	263,329.71	CONTRACTUAL ALLOW	128,728.15
NON-COVERD CHARGES	46,435.52	TOTAL MEDICAID LIAB	134,601.56
		LESS: COB	383.33
		LESS: COPAYMENT	567.00
		REIMBURSEMENT	133,651.23
		ALL OTHER	120,283.60
		FEE SCHEDULE-LAB	12,590.38
		INJECTABLE DRUGS	777.25

TOTAL NUMBER OF CLAIMS 517

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,876.80	1,092.60	OTHER LAB	1,214.31	0.00
MED/SURG SUPPLY	3,861.36	354.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,726.66	1,941.28	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,622.61	27,352.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	285.00	FEE SCHEDULE LAB	95,120.31	6,133.60
EKG/ECG	3,659.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,731.00	1,687.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	357.06	42.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,399.48	347.49	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,064.89	2,264.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,325.25	1,835.37	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,478.54	1,191.09			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,891.74	1,435.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	472.57			

TOTAL ANCILLARY	263,329.71	46,435.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	263,329.71	46,435.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,497.70	ADJUSTMENTS	678.02
COVERED CHARGES	12,298.48	CONTRACTUAL ALLOW	10,684.20
NON-COVERD CHARGES	199.22	TOTAL MEDICAID LIAB	1,614.28
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	1,569.28
		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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	407.30	22.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	321.48	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	1,912.55	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	85.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,520.16	41.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	973.21	73.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	62.93	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,298.48	199.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,298.48	199.22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	740,530.09	ADJUSTMENTS	0.00
COVERED CHARGES	719,630.09	CONTRACTUAL ALLOW	460,628.99
NON-COVERD CHARGES	20,900.00	TOTAL MEDICAID LIAB	259,001.10
		LESS: COB	2,299.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	256,701.18

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	113	0	50,850.00	20,900.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	113	0	50,850.00	20,900.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	17	0	20,250.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	20,250.00	0.00
TOTAL ACCOMODATIONS	130	0	71,100.00	20,900.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,098.00	0.00	OTHER LAB	766.90	0.00
MED/SURG SUPPLY	88,559.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	133,312.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,683.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,419.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,088.00	0.00	MRI SERVICES	4,939.90	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,790.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,865.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,251.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,687.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,100.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,161.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,049.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,727.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	242.00	0.00			

TOTAL ANCILLARY	648,530.09	0.00
TOTAL ACCOMODATIONS	71,100.00	20,900.00
TOTAL CHARGES	719,630.09	20,900.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL
163 S TALLAHASSEE ST
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,644,465.61	ADJUSTMENTS	16,907.00
COVERED CHARGES	1,482,546.16	CONTRACTUAL ALLOW	1,086,222.98
NON-COVERD CHARGES	161,919.45	TOTAL MEDICAID LIAB	396,323.18
		LESS: COB	0.00
		LESS: COPAYMENT	1,176.00
		REIMBURSEMENT	395,147.18
		ALL OTHER	353,642.78
		FEE SCHEDULE-LAB	34,649.23
		INJECTABLE DRUGS	6,855.17

TOTAL NUMBER OF CLAIMS 1,073

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,793.00	3,137.00	OTHER LAB	41,117.40	0.00
MED/SURG SUPPLY	102,334.82	104.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,266.10	7,007.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	389,429.80	33,131.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	368,044.22	6,155.74
EKG/ECG	24,442.00	288.00	MRI SERVICES	36,728.70	3,106.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,173.00	3,491.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,440.02	8,173.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,165.80	2,278.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,744.20	31,477.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,689.00	32,485.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,030.50	3,559.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,500.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	7,989.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,119.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	527.70	19,536.00			

TOTAL ANCILLARY	1,482,546.16	161,919.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,482,546.16	161,919.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,181.10	ADJUSTMENTS	0.00
COVERED CHARGES	5,043.10	CONTRACTUAL ALLOW	968.35
NON-COVERD CHARGES	2,138.00	TOTAL MEDICAID LIAB	4,074.75
		LESS: COB	4,050.75
		LESS: COPAYMENT	24.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	97.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	261.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	593.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,968.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,439.30	0.00
EKG/ECG	144.00	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	1,605.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	73.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,043.10	2,138.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,043.10	2,138.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	154,818.53	ADJUSTMENTS	1,550.00
COVERED CHARGES	149,470.60	CONTRACTUAL ALLOW	144,540.60
NON-COVERD CHARGES	5,347.93	TOTAL MEDICAID LIAB	4,930.00
		LESS: COB	0.00
		LESS: COPAYMENT	201.00
		REIMBURSEMENT	4,729.00
		TOTAL NUMBER OF CLAIMS	89

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,445.00	97.00	OTHER LAB	489.90	0.00
MED/SURG SUPPLY	3,097.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,928.80	226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,199.40	1,968.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,041.10	528.93
EKG/ECG	720.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	91.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,850.40	748.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,736.00	1,780.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	872.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	149,470.60	5,347.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	149,470.60	5,347.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,416.28	ADJUSTMENTS	4,956.41
COVERED CHARGES	19,839.28	CONTRACTUAL ALLOW	14,882.87
NON-COVERD CHARGES	1,577.00	TOTAL MEDICAID LIAB	4,956.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,956.41
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	370.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,098.28	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	4,861.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	982.00	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	2,595.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,333.00	1,071.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	506.00			

TOTAL ANCILLARY	19,839.28	1,577.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,839.28	1,577.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	403,731.92	ADJUSTMENTS	0.00
COVERED CHARGES	393,196.92	CONTRACTUAL ALLOW	118,421.84
NON-COVERD CHARGES	10,535.00	TOTAL MEDICAID LIAB	274,775.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	274,775.08

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	143	0	56,875.00	9,075.00
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	143	0	56,875.00	9,075.00
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	143	0	56,875.00	9,075.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,200.02	0.00	OTHER LAB	1,364.00	0.00
MED/SURG SUPPLY	28,413.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	190.90	0.00
RADIOLOGY-DIAGNOSTIC	6,396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,224.00	663.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,385.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	20,548.00	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	40,081.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	220.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,062.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,032.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	894.00	0.00			
BLOOD	465.00	0.00			
BLOOD STORAGE & PRO.	0.00	797.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	336,321.92	1,460.00
TOTAL ACCOMODATIONS	56,875.00	9,075.00
TOTAL CHARGES	393,196.92	10,535.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	717,372.95	ADJUSTMENTS	25,193.50
COVERED CHARGES	617,094.00	CONTRACTUAL ALLOW	421,985.91
NON-COVERD CHARGES	100,278.95	TOTAL MEDICAID LIAB	195,108.09
		LESS: COB	1,435.44
		LESS: COPAYMENT	615.00
		REIMBURSEMENT	193,057.65
		ALL OTHER	153,698.63
		FEE SCHEDULE-LAB	37,452.21
		INJECTABLE DRUGS	1,906.81

TOTAL NUMBER OF CLAIMS 1,032

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,473.00	4,603.00	OTHER LAB	21,803.00	0.00
MED/SURG SUPPLY	10,790.00	5.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	62.95
RADIOLOGY-DIAGNOSTIC	32,044.00	9,768.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,011.00	19,412.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,263.00	1,545.00	FEE SCHEDULE LAB	216,050.00	14,746.00
EKG/ECG	9,477.50	10,832.00	MRI SERVICES	1,179.00	0.00
IV THERAPY	5,163.00	1,963.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,642.00	6,222.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,828.50	1,947.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	885.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,024.00	2,116.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	189,160.00	16,762.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,830.00	2,991.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,380.00	1,947.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,772.00	2,490.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,101.00	1,527.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,796.00	958.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,422.00	382.00			

TOTAL ANCILLARY	617,094.00	100,278.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	617,094.00	100,278.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,961.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,224.50	CONTRACTUAL ALLOW	2,711.03
NON-COVERD CHARGES	2,737.00	TOTAL MEDICAID LIAB	4,513.47
		LESS: COB	4,508.11
		LESS: COPAYMENT	5.36
		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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	276.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,687.00	397.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,034.50	110.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	282.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,224.50	2,737.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,224.50	2,737.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	79,181.25	ADJUSTMENTS	3,768.02
COVERED CHARGES	71,211.00	CONTRACTUAL ALLOW	62,545.90
NON-COVERD CHARGES	7,970.25	TOTAL MEDICAID LIAB	8,665.10
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	8,446.10
		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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	551.00	134.00	OTHER LAB	608.00	0.00
MED/SURG SUPPLY	430.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,503.00	1,134.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,894.00	2,388.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,070.00	2,298.00
EKG/ECG	992.00	820.00	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	382.50	26.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,935.50	822.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,845.00	154.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	194.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	71,211.00	7,970.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	71,211.00	7,970.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,527.75	ADJUSTMENTS	5,545.23
COVERED CHARGES	21,836.00	CONTRACTUAL ALLOW	16,290.77
NON-COVERD CHARGES	691.75	TOTAL MEDICAID LIAB	5,545.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,545.23

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	694.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,461.00	299.00
EKG/ECG	0.00	328.00	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	8.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,923.00	56.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,284.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,836.00	691.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,836.00	691.75

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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	11,524.88	ADJUSTMENTS	0.00
COVERED CHARGES	9,540.88	CONTRACTUAL ALLOW	5,432.99
NON-COVERD CHARGES	1,984.00	TOTAL MEDICAID LIAB	4,107.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,107.89

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	1,016.00	1,984.00
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	1,016.00	1,984.00
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	1,016.00	1,984.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,972.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	832.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,197.34	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	285.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	689.80	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	1,770.10	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	902.66	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	873.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,524.88	0.00
TOTAL ACCOMODATIONS	1,016.00	1,984.00
TOTAL CHARGES	9,540.88	1,984.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	313,075.72	ADJUSTMENTS	361.35
COVERED CHARGES	244,257.90	CONTRACTUAL ALLOW	179,541.48
NON-COVERD CHARGES	68,817.82	TOTAL MEDICAID LIAB	64,716.42
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	64,620.42
		ALL OTHER	55,563.11
		FEE SCHEDULE-LAB	9,057.31
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 263

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,605.71	0.00	OTHER LAB	5,854.05	0.00
MED/SURG SUPPLY	6,764.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,981.05	3,684.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,013.40	23,604.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,863.38	2,488.28
EKG/ECG	7,932.70	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	10,704.47	2,477.46	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,794.27	2,915.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,112.31	29,812.29	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	131.92	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,651.85	505.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,548.00	792.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	873.70	873.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,558.14	1,359.70			

TOTAL ANCILLARY	244,257.90	68,817.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	244,257.90	68,817.82

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,874.17	ADJUSTMENTS	47.00
COVERED CHARGES	15,604.65	CONTRACTUAL ALLOW	13,804.65
NON-COVERD CHARGES	269.52	TOTAL MEDICAID LIAB	1,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	1,749.00
		TOTAL NUMBER OF CLAIMS	30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	972.56	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	566.70	131.20	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	2,564.32	72.36
EKG/ECG	517.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	586.74	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	709.50	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	9,047.85	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	65.96	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	396.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	243.18	0.00			

TOTAL ANCILLARY	15,604.65	269.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,604.65	269.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,541,687.32	ADJUSTMENTS	101,562.94
COVERED CHARGES	16,848,082.32	CONTRACTUAL ALLOW	11,997,458.25
NON-COVERD CHARGES	693,605.00	TOTAL MEDICAID LIAB	4,850,624.07
		LESS: COB	81,629.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,768,994.15

TOTAL NUMBER OF ADMISSIONS 516

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,622	0	2,566,004.00	478,770.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,622	0	2,566,004.00	478,770.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	747	0	2,307,042.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	747	0	2,307,042.00	0.00
TOTAL ACCOMODATIONS	2,369	0	4,873,046.00	478,770.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	948,301.00	0.00	OTHER LAB	131,516.00	0.00
MED/SURG SUPPLY	188,570.00	3,606.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,542,205.00	0.00	EDUCATION & TRAINING	2,579.00	0.00
RADIOLOGY-DIAGNOSTIC	478,646.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,410,566.00	24,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,260.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	230,914.00	0.00	MRI SERVICES	178,845.00	0.00
IV THERAPY	547,113.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,208,228.00	103.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	525,283.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	332,785.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	106,692.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,378,976.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	191,182.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,284.00
LABORATORY PATHOLOGIC	113,074.00	0.00	INJECTABLE DRUGS	749,090.62	0.00
RADIOLOGY THERAPEUTIC	5,219.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,532.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,451.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	415,544.00	107,030.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,004.00	2,745.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,300.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,140.00
OTHER IMAGING SERVICE	120,253.00	11,309.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	115,832.00	8,498.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,205.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	489,575.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,815.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	186,480.00	0.00			

TOTAL ANCILLARY	11,975,036.32	214,835.00
TOTAL ACCOMODATIONS	4,873,046.00	478,770.00
TOTAL CHARGES	16,848,082.32	693,605.00

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2217256007779	08/24/17 - 08/28/17	09/18/17	0.00	4,793.00	0.00	0.00	0.00
615	2017320087495	11/02/17 - 11/07/17	12/04/17	0.00	4,793.00	0.00	0.00	0.00
615	2017333077699	11/15/17 - 11/18/17	12/04/17	0.00	2,605.00	0.00	0.00	0.00
615	2317360000005	10/31/17 - 11/01/17	01/22/18	0.00	4,793.00	0.00	880.34	0.00
615	2318023000225	08/01/17 - 08/02/17	02/12/18	0.00	4,793.00	0.00	0.00	0.00
615	2018071030542	02/07/18 - 02/09/18	03/19/18	0.00	4,793.00	0.00	0.00	0.00
615	2218089011316	02/26/18 - 03/01/18	04/02/18	0.00	4,793.00	0.00	0.00	0.00
615	2218109003100	03/30/18 - 03/30/18	04/23/18	0.00	2,605.00	0.00	0.00	0.00
615	2018180063447	06/20/18 - 06/22/18	07/09/18	0.00	4,793.00	0.00	0.00	0.00
615	2318261000117	04/13/18 - 04/23/18	10/15/18	0.00	4,793.00	0.00	0.00	0.00
615	2018285062700	05/26/18 - 05/30/18	10/22/18	0.00	4,793.00	0.00	0.00	0.00
615	2019162003227	12/05/17 - 12/13/17	06/17/19	0.00	4,793.00	0.00	0.00	0.00
TOTAL				0.00	53,140.00	0.00	880.34	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,672.42	ADJUSTMENTS	0.00
COVERED CHARGES	131,432.00	CONTRACTUAL ALLOW	94,501.74
NON-COVERD CHARGES	39,240.42	TOTAL MEDICAID LIAB	36,930.26
		LESS: COB	36,930.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	27	0	37,968.00	4,746.00
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	27	0	37,968.00	4,746.00
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	27	0	37,968.00	4,746.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,873.00	1,392.00	OTHER LAB	2,023.00	0.00
MED/SURG SUPPLY	3,288.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,879.00	2,736.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957.00	428.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,084.00	10,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	826.00	366.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	439.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,147.00	827.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,065.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,479.00	354.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,348.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,273.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,855.00	2,285.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	908.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	2,301.00	INJECTABLE DRUGS	28,298.00	2,910.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	594.00	328.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,149.00	1,149.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,012.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,464.00	34,494.42
TOTAL ACCOMODATIONS	37,968.00	4,746.00
TOTAL CHARGES	131,432.00	39,240.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,855,363.80	ADJUSTMENTS	407,002.43
COVERED CHARGES	6,868,821.95	CONTRACTUAL ALLOW	5,634,721.94
NON-COVERD CHARGES	986,541.85	TOTAL MEDICAID LIAB	1,234,100.01
		LESS: COB	960.13
		LESS: COPAYMENT	1,500.80
		REIMBURSEMENT	1,231,639.08
		ALL OTHER	1,116,223.87
		FEE SCHEDULE-LAB	81,222.29
		INJECTABLE DRUGS	34,192.92

TOTAL NUMBER OF CLAIMS 1,999

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,207.00	53.00	OTHER LAB	99,075.00	6,860.00
MED/SURG SUPPLY	23,776.00	17,802.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	404.00
RADIOLOGY-DIAGNOSTIC	380,407.00	29,858.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,104,097.00	278,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,259.00	2,352.09	FEE SCHEDULE LAB	825,317.00	24,585.00
EKG/ECG	144,477.00	0.00	MRI SERVICES	143,658.00	49,711.00
IV THERAPY	460,062.00	29,748.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	474,719.60	133,262.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,182.00	7,539.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,374.00	3,829.00	AMBULANCE	0.00	0.00
GI SERVICES	207,159.00	18,436.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,752,685.00	5,555.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,005.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	612.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	314,797.35	56,937.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,447.00	9,150.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,761.00	3,339.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	112,225.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,363.00	2,349.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,417.00	70,200.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23,965.00
OTHER IMAGING SERVICE	153,060.00	28,827.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,986.00	8,498.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,036.00	39,900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,873.00	21,592.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,695.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	102,927.00	175.00			

TOTAL ANCILLARY	6,868,821.95	986,541.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,868,821.95	986,541.85

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017321004371	10/27/17 - 10/27/17	11/20/17	0.00	2,605.00	0.00	0.00	0.00
615	2017321004371	10/27/17 - 10/27/17	11/20/17	0.00	2,188.00	0.00	0.00	0.00
615	2018009003412	11/18/17 - 11/18/17	01/15/18	0.00	2,605.00	0.00	0.00	0.00
615	2018009003412	11/18/17 - 11/18/17	01/15/18	0.00	2,188.00	0.00	0.00	0.00
615	2018060080634	01/24/18 - 01/24/18	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018060080634	01/24/18 - 01/24/18	03/05/18	0.00	2,188.00	0.00	0.00	0.00
615	2018060080639	01/25/18 - 01/25/18	03/05/18	0.00	2,605.00	0.00	0.00	0.00
615	2018060080639	01/25/18 - 01/25/18	03/05/18	0.00	2,188.00	0.00	0.00	0.00
615	2018130110853	04/26/18 - 04/26/18	05/14/18	0.00	2,605.00	0.00	0.00	0.00
615	2018130110853	04/26/18 - 04/26/18	05/14/18	0.00	2,188.00	0.00	0.00	0.00
TOTAL				0.00	23,965.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	118,757.20	ADJUSTMENTS	0.00
COVERED CHARGES	80,421.20	CONTRACTUAL ALLOW	16,851.12
NON-COVERD CHARGES	38,336.00	TOTAL MEDICAID LIAB	63,570.08
		LESS: COB	63,563.95
		LESS: COPAYMENT	6.13
		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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,196.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	446.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,730.00	626.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	22,992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,860.00	1,132.00
EKG/ECG	439.00	0.00	MRI SERVICES	0.00	6,728.00
IV THERAPY	6,823.00	151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,512.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	127.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,185.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,930.20	1,182.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	4,207.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,769.00	1,318.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	80,421.20	38,336.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,421.20	38,336.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	495,145.60	ADJUSTMENTS	920.98
COVERED CHARGES	468,663.60	CONTRACTUAL ALLOW	454,622.66
NON-COVERD CHARGES	26,482.00	TOTAL MEDICAID LIAB	14,040.94
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	13,647.94
		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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,570.00	0.00	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	469.00	44.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,842.00	702.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,473.00	20,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,556.00	842.00
EKG/ECG	3,951.00	0.00	MRI SERVICES	3,476.00	0.00
IV THERAPY	32,866.00	755.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,914.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,012.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,164.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	233,302.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,319.60	2,070.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,451.00	1,476.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,360.00	0.00			

TOTAL ANCILLARY	468,663.60	26,482.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	468,663.60	26,482.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,104.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,708.00	CONTRACTUAL ALLOW	3,361.68
NON-COVERD CHARGES	1,396.00	TOTAL MEDICAID LIAB	2,346.32
		LESS: COB	2,346.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.00	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	1,282.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	800.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,986.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	552.00	1,324.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,708.00	1,396.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,708.00	1,396.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338,587.76	ADJUSTMENTS	27,617.35
COVERED CHARGES	287,532.16	CONTRACTUAL ALLOW	215,688.05
NON-COVERD CHARGES	51,055.60	TOTAL MEDICAID LIAB	71,844.11
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	71,808.11

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

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,218.00	0.00	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	533.00	5,354.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	702.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,648.00	893.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,034.00	1,226.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,204.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,848.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,285.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,530.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	159,736.16	41,907.60
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	1,675.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	11,210.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	492.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,380.00	0.00			

TOTAL ANCILLARY	287,532.16	51,055.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	287,532.16	51,055.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,633,896.30	ADJUSTMENTS	439,787.34
COVERED CHARGES	12,383,901.05	CONTRACTUAL ALLOW	8,589,351.85
NON-COVERD CHARGES	249,995.25	TOTAL MEDICAID LIAB	3,794,549.20
		LESS: COB	31,526.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,763,022.67

TOTAL NUMBER OF ADMISSIONS 544

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,104	0	909,690.00	143,454.00
ROUTINE NURSERY	262	0	207,572.00	11,736.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,366	0	1,117,262.00	155,190.00
SPECIAL CARE SERVICES				
CCU	267	0	399,850.00	0.00
ICU	230	0	460,230.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	497	0	860,080.00	0.00
TOTAL ACCOMODATIONS	1,863	0	1,977,342.00	155,190.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	576,752.81	0.00	OTHER LAB	53,104.50	0.00
MED/SURG SUPPLY	521,981.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,839,235.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205,721.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	646,273.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,069.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	160,577.75	0.00	MRI SERVICES	45,112.25	0.00
IV THERAPY	5,768.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,815,858.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	379,594.22	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	546,229.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,186.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	868,613.70	1,366.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	144,109.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	252.00	0.00	INJECTABLE DRUGS	1,044,163.47	0.00
RADIOLOGY THERAPEUTIC	5,254.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,012.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,396.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,020.00	2,500.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	229,207.75	0.00
LITHOTRIPSY	21,140.50	0.00	NO CC/INVALID REV CODE	0.00	4,948.00
OTHER IMAGING SERVICE	83,747.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	196,924.25	74,690.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,115.25	11,300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	592,062.60	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	17,075.25	0.00			

TOTAL ANCILLARY	10,406,559.05	94,805.25
TOTAL ACCOMODATIONS	1,977,342.00	155,190.00
TOTAL CHARGES	12,383,901.05	249,995.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017264042164	09/06/17 - 09/09/17	09/25/17	0.00	2,474.00	0.00	0.00	0.00
615	2018050021386	12/27/17 - 01/02/18	02/26/18	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	4,948.00	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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,223,644.83	ADJUSTMENTS	441,900.80
COVERED CHARGES	13,687,410.69	CONTRACTUAL ALLOW	11,371,570.68
NON-COVERD CHARGES	1,536,234.14	TOTAL MEDICAID LIAB	2,315,840.01
		LESS: COB	1,069.70
		LESS: COPAYMENT	9,007.56
		REIMBURSEMENT	2,305,762.75
		ALL OTHER	1,949,711.12
		FEE SCHEDULE-LAB	161,131.24
		INJECTABLE DRUGS	194,920.39

TOTAL NUMBER OF CLAIMS 4,652

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,883.50	771.38	OTHER LAB	94,734.50	1,309.50
MED/SURG SUPPLY	314,652.31	15,451.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	606,655.25	13,350.00	OTHER THERAPEUTIC SVC	735.00	735.00
CT SCAN	1,891,781.75	268,437.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	81,602.25	16,905.25	FEE SCHEDULE LAB	1,730,535.14	64,154.75
EKG/ECG	219,162.50	8,827.00	MRI SERVICES	483,352.00	9,536.25
IV THERAPY	193,246.75	3,969.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,384,205.58	354,284.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	303,386.25	91,101.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	248,141.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,546,460.92	51,665.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	134,902.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,746.96	100,864.42
RADIOLOGY THERAPEUTIC	654,157.01	85,533.81	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,173.75	6,504.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,235.50	3,707.83	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	114,150.96	14,310.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,941.99	52,946.90
LITHOTRIPSY	126,843.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	391,468.25	41,015.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,283.50	11,731.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	244,178.00	97,969.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	332,956.00	146,626.75			
AMBULATORY SURGERY	87,834.75	30,174.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	155,540.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816,464.00	42,850.11			

TOTAL ANCILLARY	13,687,410.69	1,534,734.14
TOTAL ACCOMODATIONS	0.00	1,500.00
TOTAL CHARGES	13,687,410.69	1,536,234.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	58,564.18	ADJUSTMENTS	0.00
COVERED CHARGES	45,104.38	CONTRACTUAL ALLOW	21,509.94
NON-COVERD CHARGES	13,459.80	TOTAL MEDICAID LIAB	23,594.44
		LESS: COB	23,567.44
		LESS: COPAYMENT	27.00
		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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.40	3.00	OTHER LAB	688.50	0.00
MED/SURG SUPPLY	958.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,833.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,585.00	2,675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,082.50	332.00	FEE SCHEDULE LAB	7,476.50	356.50
EKG/ECG	315.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,805.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	920.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,578.75	583.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	589.14	483.20
RADIOLOGY THERAPEUTIC	269.00	6,412.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	236.75	236.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	482.50	297.00	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	NO CC/INVALID REV CODE	0.00	67.60
OTHER IMAGING SERVICE	1,224.25	631.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,412.50	487.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	894.25			

TOTAL ANCILLARY	45,104.38	13,459.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,104.38	13,459.80

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
363	2217244009844	07/27/17 - 07/27/17	09/04/17	0.00	67.60	0.00	3,073.49	0.00
TOTAL				0.00	67.60	0.00	3,073.49	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	963,534.89	ADJUSTMENTS	964.92
COVERED CHARGES	929,215.81	CONTRACTUAL ALLOW	901,559.07
NON-COVERD CHARGES	34,319.08	TOTAL MEDICAID LIAB	27,656.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,050.00
		REIMBURSEMENT	26,606.74
		TOTAL NUMBER OF CLAIMS	494

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,950.08	35.00	OTHER LAB	3,627.75	0.00
MED/SURG SUPPLY	6,624.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	125.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,235.25	2,881.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	171,463.00	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	171,500.75	6,038.50
EKG/ECG	25,220.00	1,261.00	MRI SERVICES	11,902.25	0.00
IV THERAPY	1,332.00	545.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,110.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	451,092.35	8,436.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,719.32	35.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	272.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,897.75	6,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,639.25	540.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,629.00	0.00			

TOTAL ANCILLARY	929,215.81	34,319.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	929,215.81	34,319.08

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,069.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,069.00	CONTRACTUAL ALLOW	1,066.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	354.00	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	715.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,069.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,069.00	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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,559,702.11	ADJUSTMENTS	64,107.33
COVERED CHARGES	1,465,543.62	CONTRACTUAL ALLOW	1,103,206.95
NON-COVERD CHARGES	94,158.49	TOTAL MEDICAID LIAB	362,336.67
		LESS: COB	0.00
		LESS: COPAYMENT	904.64
		REIMBURSEMENT	361,432.03

TOTAL NUMBER OF CLAIMS 62

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,124.43	35.00	OTHER LAB	2,289.50	0.00
MED/SURG SUPPLY	47,575.02	4,883.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,331.00	1,748.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,491.25	8,375.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	716.75	FEE SCHEDULE LAB	52,271.75	2,793.00
EKG/ECG	3,467.75	315.25	MRI SERVICES	4,076.00	4,152.50
IV THERAPY	27,478.25	545.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	152,364.00	10,996.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	261,822.00	27,940.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,013.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,669.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	426,707.32	2,855.47
RADIOLOGY THERAPEUTIC	212,788.44	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,072.50	3,379.13	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,833.46	17,738.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,845.75	1,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,667.00	1,940.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,162.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,001.50	2,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	89,317.50	730.25			

TOTAL ANCILLARY	1,465,543.62	94,158.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,465,543.62	94,158.49

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

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,590,934.48	ADJUSTMENTS	1,003,909.09
COVERED CHARGES	28,170,089.96	CONTRACTUAL ALLOW	22,925,330.71
NON-COVERD CHARGES	1,420,844.52	TOTAL MEDICAID LIAB	5,244,759.25
		LESS: COB	20,853.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,223,905.49

TOTAL NUMBER OF ADMISSIONS 812

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,340	0	2,838,820.00	593,037.00
ROUTINE NURSERY	867	0	1,109,335.00	358,483.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,207	0	3,948,155.00	951,520.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	285	0	1,226,843.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	285	0	1,226,843.00	0.00
TOTAL ACCOMODATIONS	3,492	0	5,174,998.00	951,520.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,131,411.74	38,720.50	OTHER LAB	91,686.00	0.00
MED/SURG SUPPLY	998,956.50	2,127.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,580,931.14	56,366.02	EDUCATION & TRAINING	1,219.00	0.00
RADIOLOGY-DIAGNOSTIC	358,987.00	429.00	OTHER THERAPEUTIC SVC	0.00	3,213.00
CT SCAN	1,282,568.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	201,125.00	2,757.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	134,080.00	0.00	MRI SERVICES	403,474.00	5,276.00
IV THERAPY	47,604.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,116,288.00	12,444.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	966,675.00	3,268.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,444,621.00	39.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	325,077.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	763,212.00	74.00	SPECIAL SERVICES	0.00	73,772.00
RECOVERY ROOM	255,044.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	59,046.00
LABORATORY PATHOLOGIC	215,130.00	0.00	INJECTABLE DRUGS	4,372,294.50	92,926.00
RADIOLOGY THERAPEUTIC	21,014.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,065.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,426.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	172,520.00	0.00	PATIENT CONVENIENCE	0.00	380.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.00	193.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	537,390.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,282.00	44,166.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	324,223.00	55,258.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	120,766.08	18,870.00			
AUDIOLOGY	101,809.00	0.00			
CARDIOLOGY	625,478.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,558.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,137.00	0.00			

TOTAL ANCILLARY	22,995,091.96	469,324.52
TOTAL ACCOMODATIONS	5,174,998.00	951,520.00
TOTAL CHARGES	28,170,089.96	1,420,844.52

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	603,010.00	ADJUSTMENTS	0.00
COVERED CHARGES	595,663.00	CONTRACTUAL ALLOW	301,282.70
NON-COVERD CHARGES	7,347.00	TOTAL MEDICAID LIAB	294,380.30
		LESS: COB	294,380.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	42	0	52,365.00	2,235.00
ROUTINE NURSERY	8	0	29,758.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	50	0	82,123.00	2,235.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	5	0	22,005.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	22,005.00	0.00
TOTAL ACCOMODATIONS	55	0	104,128.00	2,235.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,603.50	0.00	OTHER LAB	2,066.00	0.00
MED/SURG SUPPLY	37,767.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	41,649.00	0.00	EDUCATION & TRAINING	83.00	0.00
RADIOLOGY-DIAGNOSTIC	8,878.00	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	2,576.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,429.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	79,781.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,021.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,510.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,065.00	0.00	SPECIAL SERVICES	0.00	5,112.00
RECOVERY ROOM	5,472.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,439.00	0.00	INJECTABLE DRUGS	27,321.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,098.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	565.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,728.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,218.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,496.00	0.00			
AUDIOLOGY	863.00	0.00			
CARDIOLOGY	79,906.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	491,535.00	5,112.00
TOTAL ACCOMODATIONS	104,128.00	2,235.00
TOTAL CHARGES	595,663.00	7,347.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,516,310.74	ADJUSTMENTS	862,894.88
COVERED CHARGES	16,907,684.24	CONTRACTUAL ALLOW	14,576,298.65
NON-COVERD CHARGES	1,608,626.50	TOTAL MEDICAID LIAB	2,331,385.59
		LESS: COB	6,531.12
		LESS: COPAYMENT	5,540.52
		REIMBURSEMENT	2,319,313.95
		ALL OTHER	1,957,575.16
		FEE SCHEDULE-LAB	143,036.67
		INJECTABLE DRUGS	218,702.12

TOTAL NUMBER OF CLAIMS 3,210

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343,744.20	6,128.00	OTHER LAB	218,062.00	1,198.00
MED/SURG SUPPLY	360,321.50	3,885.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,386.00	0.00
RADIOLOGY-DIAGNOSTIC	502,515.00	13,537.00	OTHER THERAPEUTIC SVC	0.00	691.00
CT SCAN	2,126,556.00	167,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169,830.00	24,564.00	FEE SCHEDULE LAB	2,361,898.33	85,448.00
EKG/ECG	199,708.00	1,104.00	MRI SERVICES	717,725.00	88,336.00
IV THERAPY	342,958.00	39,378.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,295,375.00	88,704.00	DURABLE MED. EQUIP.	0.00	8,454.00
LABOR/DELIVERY ROOM	36,885.00	0.00	REHAB THERAPY	0.00	285.00
RESPIRATORY SERVICES	93,667.00	186.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	302,777.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,952,035.00	93,458.00	SPECIAL SERVICES	0.00	516.00
RECOVERY ROOM	260,966.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,552.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,060,147.00	749,346.50
RADIOLOGY THERAPEUTIC	1,212,883.00	3,479.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	64,371.00	23,367.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,146.00	20,419.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	15,438.00	PATIENT CONVENIENCE	0.00	95.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	49,027.00	1,879.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,640.00	880.00	IMPL DEV CHARGE PATIENTS	178,140.00	2,385.00
LITHOTRIPSY	24,520.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	534,239.00	99,563.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,693.00	1,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	101,570.00	16,871.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	220,434.00	45,149.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,171.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124,294.21	3,411.00			

TOTAL ANCILLARY	16,907,684.24	1,608,626.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,907,684.24	1,608,626.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	552,739.00	ADJUSTMENTS	0.00
COVERED CHARGES	398,002.00	CONTRACTUAL ALLOW	192,148.92
NON-COVERD CHARGES	154,737.00	TOTAL MEDICAID LIAB	205,853.08
		LESS: COB	205,744.37
		LESS: COPAYMENT	108.71
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,205.00	0.00	OTHER LAB	1,395.00	0.00
MED/SURG SUPPLY	10,743.00	474.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,509.00	393.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,503.00	20,548.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,946.00	1,252.00	FEE SCHEDULE LAB	64,389.00	7,034.00
EKG/ECG	2,594.00	0.00	MRI SERVICES	5,276.00	0.00
IV THERAPY	9,916.00	382.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,108.00	38,351.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,076.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,183.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,926.00	6,532.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,704.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,646.00	54,095.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	386.00	42.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	440.00	IMPL DEV CHARGE PATIENTS	1,982.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,409.00	25,194.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,876.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,798.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,934.00	0.00			

TOTAL ANCILLARY	398,002.00	154,737.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	398,002.00	154,737.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	364,238.50	ADJUSTMENTS	3,285.29
COVERED CHARGES	341,344.50	CONTRACTUAL ALLOW	329,115.92
NON-COVERD CHARGES	22,894.00	TOTAL MEDICAID LIAB	12,228.58
		LESS: COB	0.00
		LESS: COPAYMENT	246.00
		REIMBURSEMENT	11,982.58
		TOTAL NUMBER OF CLAIMS	209

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,490.00	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	23,005.00	1,563.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,675.00	7,661.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	71,918.00	6,253.00
EKG/ECG	4,416.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	176,102.00	1,554.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,725.50	109.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	42.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,732.00	1,884.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,891.00	3,828.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	341,344.50	22,894.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	341,344.50	22,894.00

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
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	50,781.00	ADJUSTMENTS	0.00
COVERED CHARGES	47,340.50	CONTRACTUAL ALLOW	29,662.10
NON-COVERD CHARGES	3,440.50	TOTAL MEDICAID LIAB	17,678.40
		LESS: COB	17,657.40
		LESS: COPAYMENT	21.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621.00	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	492.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,154.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,311.00	1,422.00
EKG/ECG	368.00	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	20,363.00	1,204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,307.50	772.50
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	42.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,724.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,340.50	3,440.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,340.50	3,440.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,329,280.56	ADJUSTMENTS	103,323.40
COVERED CHARGES	2,831,073.06	CONTRACTUAL ALLOW	2,515,894.25
NON-COVERD CHARGES	498,207.50	TOTAL MEDICAID LIAB	315,178.81
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	314,995.81

TOTAL NUMBER OF CLAIMS 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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,553.50	1,219.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	199,245.50	99.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,149.00	49,129.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,957.00	11,070.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,425.00	FEE SCHEDULE LAB	66,579.00	2,356.00
EKG/ECG	6,992.00	590.00	MRI SERVICES	24,391.00	9,866.00
IV THERAPY	68,889.00	7,159.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	525,466.00	146,520.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,495.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,485.00	772.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,061.00	1,317.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,328.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,102,645.50	230,182.50
RADIOLOGY THERAPEUTIC	23,899.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,938.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	800.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,292.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,383.00	225.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	455,634.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,559.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,774.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,766.00	11,424.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,921.00	2,869.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,196.56	3,627.00			

TOTAL ANCILLARY	2,831,073.06	498,207.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,831,073.06	498,207.50

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
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	155,702,064.80	ADJUSTMENTS	4,375,451.00
COVERED CHARGES	148,802,979.16	CONTRACTUAL ALLOW	122,159,988.79
NON-COVERD CHARGES	6,899,085.64	TOTAL MEDICAID LIAB	26,642,990.37
		LESS: COB	276,522.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,366,468.08

TOTAL NUMBER OF ADMISSIONS 2,676

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,164	0	10,349,732.00	778,243.00
ROUTINE NURSERY	2,396	0	2,877,677.00	531,079.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,560	0	13,227,409.00	1,309,322.00
SPECIAL CARE SERVICES				
CCU	2,916	0	7,453,232.00	221,137.00
ICU	1,830	0	5,954,458.50	353,421.50
NICU	767	0	2,436,464.00	189,236.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	92	0	441,652.00	53,860.00
BURN UNIT	6	0	32,316.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,611	0	16,318,122.50	817,654.50
TOTAL ACCOMODATIONS	16,171	0	29,545,531.50	2,126,976.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,911,602.79	917,107.30	OTHER LAB	1,157,874.10	40,127.90
MED/SURG SUPPLY	6,436,767.81	266,068.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,292,894.75	589,957.00	EDUCATION & TRAINING	53,834.00	0.00
RADIOLOGY-DIAGNOSTIC	2,982,128.00	158,340.00	OTHER THERAPEUTIC SVC	0.00	16,186.00
CT SCAN	8,671,353.00	91,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	890,143.02	31,012.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,017,595.00	17,408.00	MRI SERVICES	1,773,386.00	9,356.00
IV THERAPY	1,492,817.00	22,762.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,547,705.49	746,256.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,503,064.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,787,080.00	786,620.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,025,034.20	49,827.00	AMBULANCE	0.00	0.00
GI SERVICES	76,591.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,658,565.00	10,430.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,823,211.00	5,311.00	DRUG-SPECIFIC/HOME IV	0.00	25,480.75
LABORATORY PATHOLOGIC	693,019.70	324.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	357,516.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	329,710.44	4,538.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	394,817.35	36,236.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,166,269.00	371,250.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	76,494.00	45,825.00	TRAUMA RESPONSE	0.00	187,357.00
PSYCHIATRIC SERVICES	7,751.00	0.00	IMPL DEV CHARGE PATIENTS	5,006,482.84	4,685.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	603,021.00	9,178.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,337,673.00	279,919.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	394,398.00	2,117.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,055,046.00	19,147.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	843,273.00	21,832.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,890,330.17	5,744.00			

TOTAL ANCILLARY	119,257,447.66	4,772,109.14
TOTAL ACCOMODATIONS	29,545,531.50	2,126,976.50
TOTAL CHARGES	148,802,979.16	6,899,085.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,168,334.28	ADJUSTMENTS	0.00
COVERED CHARGES	2,154,451.28	CONTRACTUAL ALLOW	1,373,105.92
NON-COVERD CHARGES	13,883.00	TOTAL MEDICAID LIAB	781,345.36
		LESS: COB	781,345.36
		LESS: COPAYMENT	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	111	0	143,412.00	6,216.00
ROUTINE NURSERY	63	0	124,066.00	3,564.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	174	0	267,478.00	9,780.00
SPECIAL CARE SERVICES				
CCU	57	0	143,298.00	0.00
ICU	19	0	55,305.00	0.00
NICU	7	0	23,954.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	83	0	222,557.00	0.00
TOTAL ACCOMODATIONS	257	0	490,035.00	9,780.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,839.50	0.00	OTHER LAB	20,018.00	0.00
MED/SURG SUPPLY	53,141.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	175,103.00	0.00	EDUCATION & TRAINING	4,198.00	0.00
RADIOLOGY-DIAGNOSTIC	17,844.00	0.00	OTHER THERAPEUTIC SVC	0.00	598.00
CT SCAN	81,423.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,895.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,144.00	0.00	MRI SERVICES	9,228.00	0.00
IV THERAPY	14,724.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	258,395.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	308,459.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	51,063.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,475.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,987.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,811.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	928.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,189.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,637.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	11,976.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,443.00	2,113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,517.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,149.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	125,833.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,834.00	1,392.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,279.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,179.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,671.64	0.00			

TOTAL ANCILLARY	1,664,416.28	4,103.00
TOTAL ACCOMODATIONS	490,035.00	9,780.00
TOTAL CHARGES	2,154,451.28	13,883.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,848,450.05	ADJUSTMENTS	687,231.36
COVERED CHARGES	33,545,882.24	CONTRACTUAL ALLOW	29,408,279.68
NON-COVERD CHARGES	3,302,567.81	TOTAL MEDICAID LIAB	4,137,602.56
		LESS: COB	55,701.61
		LESS: COPAYMENT	9,619.31
		REIMBURSEMENT	4,072,281.64
		ALL OTHER	3,686,984.40
		FEE SCHEDULE-LAB	364,093.44
		INJECTABLE DRUGS	21,203.80

TOTAL NUMBER OF CLAIMS 9,640

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
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SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	813,713.72	1,061.65	OTHER LAB	727,338.00	1,268.00
MED/SURG SUPPLY	513,127.92	31,331.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	912.00
RADIOLOGY-DIAGNOSTIC	1,456,577.00	19,950.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,596,871.00	648,609.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	142,828.00	36,613.02	FEE SCHEDULE LAB	4,965,711.91	339,862.33
EKG/ECG	446,176.00	8,284.00	MRI SERVICES	1,334,482.00	154,050.00
IV THERAPY	1,375,304.00	78,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,032,160.18	422,044.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,516.00	0.00	REHAB THERAPY	0.00	594.00
RESPIRATORY SERVICES	193,482.00	78,224.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	910,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,649.00	4,863.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,644,665.50	100,490.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476,877.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,887.85	170,167.23
RADIOLOGY THERAPEUTIC	1,479,790.00	120,257.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	76,035.00	20,025.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,910.00	16,512.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	59,880.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	298,697.86	65,941.79	TRAUMA RESPONSE	0.00	24,297.00
PSYCHIATRIC SERVICES	73,400.00	139,011.00	IMPL DEV CHARGE PATIENTS	123,898.94	2,477.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	77.00	328.06
OTHER IMAGING SERVICE	1,135,470.00	340,852.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,285.00	1,765.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	512,584.00	51,709.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	942,497.00	265,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	232,810.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	806,476.36	97,165.73			

TOTAL ANCILLARY	33,545,882.24	3,302,567.81
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,545,882.24	3,302,567.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
3021	5917248000322	08/09/17 - 08/09/17	09/11/17	0.00	75.00	0.00	0.00	0.00
780	2017278054379	09/07/17 - 09/07/17	11/13/17	77.00	0.00	0.00	0.00	20.52
780	2017278054379	09/07/17 - 09/07/17	11/13/17	0.00	80.00	0.00	0.00	0.00
8779	5918164000637	03/15/18 - 03/15/18	06/18/18	0.00	173.06	0.00	0.00	0.00
TOTAL				77.00	328.06	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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	797,882.04	ADJUSTMENTS	0.00
COVERED CHARGES	620,700.11	CONTRACTUAL ALLOW	321,477.44
NON-COVERD CHARGES	177,181.93	TOTAL MEDICAID LIAB	299,222.67
		LESS: COB	299,103.05
		LESS: COPAYMENT	119.62
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	182

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,816.39	2,222.00	OTHER LAB	31,767.00	0.00
MED/SURG SUPPLY	9,939.77	1,412.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	378.00
RADIOLOGY-DIAGNOSTIC	26,402.00	7,346.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,011.00	45,097.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99,210.50	13,281.09
EKG/ECG	3,628.00	0.00	MRI SERVICES	20,006.00	4,678.00
IV THERAPY	43,430.00	2,851.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,026.00	45,506.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,167.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,254.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,093.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,235.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,458.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	694.25	314.00
RADIOLOGY THERAPEUTIC	26,961.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	474.00	2,358.79	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	766.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,656.00	23,960.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,008.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,829.00	21,507.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,162.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,480.20	4,497.00			

TOTAL ANCILLARY	620,700.11	177,181.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	620,700.11	177,181.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	970,595.99	ADJUSTMENTS	435.52
COVERED CHARGES	921,210.01	CONTRACTUAL ALLOW	900,413.81
NON-COVERD CHARGES	49,385.98	TOTAL MEDICAID LIAB	20,796.20
		LESS: COB	657.80
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	19,649.40
		TOTAL NUMBER OF CLAIMS	360

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,789.00	0.00	OTHER LAB	19,870.00	0.00
MED/SURG SUPPLY	5,034.09	202.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,281.00	3,038.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	117,509.00	13,653.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	159,155.00	9,070.00
EKG/ECG	8,704.00	0.00	MRI SERVICES	16,885.00	0.00
IV THERAPY	45,498.00	2,416.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,879.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,304.00	1,108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,683.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	438,040.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,160.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	5,746.00	10,304.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,236.00	9,579.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,129.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,334.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,973.92	0.00			

TOTAL ANCILLARY	921,210.01	49,385.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,210.01	49,385.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,949.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,511.00	CONTRACTUAL ALLOW	22,445.18
NON-COVERD CHARGES	438.00	TOTAL MEDICAID LIAB	18,065.82
		LESS: COB	18,056.82
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	410.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,999.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,595.00	438.00
EKG/ECG	512.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,047.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	18,134.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,511.00	438.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,511.00	438.00

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,249,429.37	ADJUSTMENTS	180,706.60
COVERED CHARGES	3,962,976.01	CONTRACTUAL ALLOW	3,660,900.83
NON-COVERD CHARGES	286,453.36	TOTAL MEDICAID LIAB	302,075.18
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	301,736.18

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,684.25	0.00
MED/SURG SUPPLY	503,705.17	107.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,075.00	111,592.00
CT SCAN	56,806.00	7,967.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,536.00	0.00
IV THERAPY	1,253.00	542.00
OPERATING ROOM	758,324.75	119,121.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,018.00	0.00
ANESTHESIA	242,285.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,500.00	0.00
RECOVERY ROOM	90,938.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	491,697.00	4,456.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	111.00	111.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	2,475.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,414.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	610,522.00	33,487.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	32,907.41	0.00
OTHER LAB	365.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,105.00	656.00
MRI SERVICES	4,678.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,640.25	2,939.25
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	1,041,936.18	5,474.86
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	3,962,976.01	286,453.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,962,976.01	286,453.36

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

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	142,564.34	ADJUSTMENTS	0.00
COVERED CHARGES	142,564.34	CONTRACTUAL ALLOW	77,335.45
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	65,228.89
		LESS: COB	65,225.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	586.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,038.53	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	7,109.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,226.00	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	4,140.00	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	124,464.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	142,564.34	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	142,564.34	0.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	38,072,206.25	ADJUSTMENTS	356,044.89
COVERED CHARGES	37,219,264.60	CONTRACTUAL ALLOW	31,127,475.68
NON-COVERD CHARGES	852,941.65	TOTAL MEDICAID LIAB	6,091,788.92
		LESS: COB	49,161.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,042,627.42

TOTAL NUMBER OF ADMISSIONS 644

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,379	0	2,373,565.00	294,502.00
ROUTINE NURSERY	86	0	63,596.00	1,541.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,465	0	2,437,161.00	296,043.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	655	0	1,819,156.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	655	0	1,819,156.00	0.00
TOTAL ACCOMODATIONS	3,120	0	4,256,317.00	296,043.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,258,765.69	1,797.50	OTHER LAB	127,532.50	0.00
MED/SURG SUPPLY	2,199,449.80	22,701.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,400,753.50	1,785.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802,057.25	0.00	OTHER THERAPEUTIC SVC	0.00	14,264.00
CT SCAN	1,492,452.00	314,531.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	651,382.22	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	344,110.00	0.00	MRI SERVICES	262,939.00	0.00
IV THERAPY	16,182.00	126.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,371,851.75	3,394.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	160,235.00	0.00	REHAB THERAPY	197.00	0.00
RESPIRATORY SERVICES	1,846,339.25	1,308.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242,663.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,313.00	5,798.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,203,270.00	632.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	205,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	33,656.50
LABORATORY PATHOLOGIC	63,197.75	0.00	INJECTABLE DRUGS	8,042,424.21	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	464,329.57	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	101,712.15	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	238,792.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,578.25	1,623.00	TRAUMA RESPONSE	0.00	19,600.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	526,831.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	234,561.75	7,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	75,721.16	125,414.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	281,520.00	2,345.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,121,918.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,214.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,514.75	0.00			

TOTAL ANCILLARY	32,962,947.60	556,898.65
TOTAL ACCOMODATIONS	4,256,317.00	296,043.00
TOTAL CHARGES	37,219,264.60	852,941.65

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 05/01/17 THROUGH 04/30/18
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	2017171002460	05/30/17 - 06/12/17	06/26/17	0.00	0.00	0.00	0.00	0.00
24	2017244092888	08/02/17 - 08/24/17	09/11/17	0.00	0.00	0.00	0.00	0.00
24	2017296027107	09/26/17 - 10/13/17	10/30/17	0.00	0.00	0.00	0.00	0.00
24	2017314070984	10/23/17 - 11/01/17	11/20/17	0.00	0.00	0.00	0.00	0.00
24	2018025099854	01/03/18 - 01/19/18	01/29/18	0.00	0.00	0.00	0.00	0.00
24	2018088091142	03/13/18 - 03/23/18	04/02/18	0.00	0.00	0.00	0.00	0.00
24	2019052098963	12/08/17 - 12/29/17	02/25/19	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,126.50	ADJUSTMENTS	0.00
COVERED CHARGES	39,817.50	CONTRACTUAL ALLOW	19,935.03
NON-COVERD CHARGES	1,309.00	TOTAL MEDICAID LIAB	19,882.47
		LESS: COB	19,882.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	4,909.00	697.00
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	4,909.00	697.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	4,909.00	697.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,649.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	788.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,532.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,277.50	0.00	OTHER THERAPEUTIC SVC	0.00	612.00
CT SCAN	3,950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	800.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	577.00	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	4,294.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,150.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,875.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,014.00	0.00			

TOTAL ANCILLARY	34,908.50	612.00
TOTAL ACCOMODATIONS	4,909.00	697.00
TOTAL CHARGES	39,817.50	1,309.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,802,151.95	ADJUSTMENTS	74,631.73
COVERED CHARGES	23,023,281.03	CONTRACTUAL ALLOW	21,432,135.89
NON-COVERD CHARGES	2,778,870.92	TOTAL MEDICAID LIAB	1,591,145.14
		LESS: COB	138.75
		LESS: COPAYMENT	3,989.73
		REIMBURSEMENT	1,587,016.66
		ALL OTHER	1,361,201.98
		FEE SCHEDULE-LAB	205,713.42
		INJECTABLE DRUGS	20,101.26

TOTAL NUMBER OF CLAIMS 4,551

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,631.80	120,086.45	OTHER LAB	136,542.00	0.00
MED/SURG SUPPLY	1,183,247.90	10,366.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,139,701.25	225,633.35	OTHER THERAPEUTIC SVC	0.00	184.00
CT SCAN	4,224,687.00	347,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	166,525.00	6,566.50	FEE SCHEDULE LAB	5,638,319.50	426,185.50
EKG/ECG	517,149.00	1,451.00	MRI SERVICES	380,434.00	5,048.00
IV THERAPY	428,148.00	38,844.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,609,891.25	365,554.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,100.00	982.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	97,836.08	15,627.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	521,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	310,263.27	141,385.93	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,442,377.00	38,951.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	203,354.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	645,310.04	549,031.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,323.00	574.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,158.00	2,226.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,520.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102,370.50	15,973.75	TRAUMA RESPONSE	0.00	153,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	148,678.30	0.00
LITHOTRIPSY	28,721.00	28,721.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	397,122.25	35,604.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,655.98	16,088.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	232,483.00	52,075.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	537,531.00	70,677.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	264,015.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	443,511.91	108,589.62			

TOTAL ANCILLARY	23,023,281.03	2,778,870.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,023,281.03	2,778,870.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	344,714.75	ADJUSTMENTS	0.00
COVERED CHARGES	292,997.30	CONTRACTUAL ALLOW	192,404.65
NON-COVERD CHARGES	51,717.45	TOTAL MEDICAID LIAB	100,592.65
		LESS: COB	100,562.65
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 53

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,625.45	6,571.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,594.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,063.25	1,643.00	OTHER THERAPEUTIC SVC	0.00	220.00
CT SCAN	49,226.00	16,906.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	76,309.25	8,001.00
EKG/ECG	6,176.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,642.00	994.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,754.00	4,711.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,103.00	1,642.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	879.00	1,419.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,010.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,324.00	1,513.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,337.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,627.75	5,388.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,141.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	115.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,471.00	900.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,770.00	708.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,361.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,467.00	1,100.00			

TOTAL ANCILLARY	292,997.30	51,717.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	292,997.30	51,717.45

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,131,122.14	ADJUSTMENTS	0.00
COVERED CHARGES	1,045,301.28	CONTRACTUAL ALLOW	1,026,169.80
NON-COVERD CHARGES	85,820.86	TOTAL MEDICAID LIAB	19,131.48
		LESS: COB	30.46
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	18,549.02
		TOTAL NUMBER OF CLAIMS	342

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,294.71	5,285.11	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,605.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,010.50	23,488.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	158,562.00	18,986.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	342,369.50	19,435.25
EKG/ECG	23,895.00	0.00	MRI SERVICES	5,411.00	0.00
IV THERAPY	27,123.00	864.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,325.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	342,201.00	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	28,052.22	15,802.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,869.25	1,960.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,690.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	893.00	0.00			

TOTAL ANCILLARY	1,045,301.28	85,820.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,045,301.28	85,820.86

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,766.55	ADJUSTMENTS	0.00
COVERED CHARGES	7,377.05	CONTRACTUAL ALLOW	2,795.76
NON-COVERD CHARGES	389.50	TOTAL MEDICAID LIAB	4,581.29
		LESS: COB	4,578.29
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 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	344.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,206.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,916.00	48.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	220.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,215.00	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	474.50	341.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,377.05	389.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,377.05	389.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	727,312.24	ADJUSTMENTS	11,075.46
COVERED CHARGES	710,641.09	CONTRACTUAL ALLOW	679,109.86
NON-COVERD CHARGES	16,671.15	TOTAL MEDICAID LIAB	31,531.23
		LESS: COB	9,124.34
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	22,370.89

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,675.75	5,743.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42,228.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,574.50	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	20,162.25	1,560.00
EKG/ECG	3,175.00	577.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290,411.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	573.00	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	4,757.00	7,825.75
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	189,143.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	675.04	965.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	147,697.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,152.00	0.00			

TOTAL ANCILLARY	710,641.09	16,671.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	710,641.09	16,671.15

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,522,454.33	ADJUSTMENTS	117,400.62
COVERED CHARGES	1,514,535.08	CONTRACTUAL ALLOW	944,847.30
NON-COVERD CHARGES	7,919.25	TOTAL MEDICAID LIAB	569,687.78
		LESS: COB	3,062.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	566,625.72

TOTAL NUMBER OF ADMISSIONS 85

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	240	0	229,200.00	6,443.00
ROUTINE NURSERY	18	0	7,794.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	258	0	236,994.00	6,443.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	24	0	36,528.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	36,528.00	0.00
TOTAL ACCOMODATIONS	282	0	273,522.00	6,443.00

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,936.78	0.00	OTHER LAB	13,969.00	0.00
MED/SURG SUPPLY	64,575.48	94.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	281,914.03	0.00	EDUCATION & TRAINING	2,445.00	0.00
RADIOLOGY-DIAGNOSTIC	23,120.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,422.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,300.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,071.00	0.00	MRI SERVICES	21,064.00	0.00
IV THERAPY	88,224.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,048.25	884.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,078.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,668.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,965.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,617.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,047.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	84,395.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,060.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,861.56	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	692.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,977.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,513.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,651.00	0.00			
AUDIOLOGY	83.00	498.00			
CARDIOLOGY	13,992.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,699.13	0.00			

TOTAL ANCILLARY	1,241,013.08	1,476.25
TOTAL ACCOMODATIONS	273,522.00	6,443.00
TOTAL CHARGES	1,514,535.08	7,919.25

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,936,338.88	ADJUSTMENTS	261,733.66
COVERED CHARGES	4,549,886.93	CONTRACTUAL ALLOW	3,682,283.33
NON-COVERD CHARGES	386,451.95	TOTAL MEDICAID LIAB	867,603.60
		LESS: COB	10,282.46
		LESS: COPAYMENT	1,749.00
		REIMBURSEMENT	855,572.14
		ALL OTHER	754,906.20
		FEE SCHEDULE-LAB	94,045.15
		INJECTABLE DRUGS	6,620.79

TOTAL NUMBER OF CLAIMS 2,361

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,954.46	4,859.00	OTHER LAB	48,574.00	0.00
MED/SURG SUPPLY	103,571.62	1,220.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	333.00	1,922.00
RADIOLOGY-DIAGNOSTIC	225,288.60	4,544.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	725,372.00	86,557.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,562.00	8,953.00	FEE SCHEDULE LAB	959,350.14	58,958.99
EKG/ECG	52,335.00	2,600.00	MRI SERVICES	61,156.00	6,293.00
IV THERAPY	192,752.00	91,142.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	251,425.50	25,554.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,581.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,126.25	9,711.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,265.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	62,028.00	10,632.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	917,639.00	7,995.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,742.00	23,717.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	106.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	769.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,324.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	140,389.00	12,812.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,203.00	1,022.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,667.00	20,487.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,044.00	1,166.00			
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	167,026.00	5,536.00			

TOTAL ANCILLARY	4,549,886.93	386,451.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,549,886.93	386,451.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,550.37	ADJUSTMENTS	0.00
COVERED CHARGES	52,171.57	CONTRACTUAL ALLOW	27,532.01
NON-COVERD CHARGES	12,378.80	TOTAL MEDICAID LIAB	24,639.56
		LESS: COB	24,632.33
		LESS: COPAYMENT	7.23
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,138.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,307.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,883.00	184.00	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	18,623.52	1,167.80
EKG/ECG	740.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,180.00	1,255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,911.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	399.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,889.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,479.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,890.00	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,696.00	1,340.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,661.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,906.00	2,094.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,166.00			
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	2,171.00	0.00			

TOTAL ANCILLARY	52,171.57	12,378.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,171.57	12,378.80

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	219,430.85	ADJUSTMENTS	5,842.46
COVERED CHARGES	205,648.85	CONTRACTUAL ALLOW	190,652.01
NON-COVERD CHARGES	13,782.00	TOTAL MEDICAID LIAB	14,996.84
		LESS: COB	649.50
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	13,951.34
		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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,387.00	157.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,943.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,643.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,062.00	6,454.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,613.00	2,257.00
EKG/ECG	1,783.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,556.00	3,690.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108.29	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	399.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,227.00	240.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,977.00	185.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	799.00	799.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	205,648.85	13,782.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	205,648.85	13,782.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,113.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,113.00	CONTRACTUAL ALLOW	4,053.73
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	59.27
		LESS: COB	56.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339.00	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	1,206.00	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	480.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,088.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,113.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,113.00	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

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 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	96,310.14	ADJUSTMENTS	0.00
COVERED CHARGES	94,502.14	CONTRACTUAL ALLOW	84,589.32
NON-COVERD CHARGES	1,808.00	TOTAL MEDICAID LIAB	9,912.82
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	9,900.82
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,250.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,287.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	30.00	63.00
RADIOLOGY-DIAGNOSTIC	0.00	721.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,887.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,015.00	52.00
EKG/ECG	149.00	185.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,505.00	774.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,009.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,093.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,179.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,193.00	13.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	855.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,425.00	0.00			

TOTAL ANCILLARY	94,502.14	1,808.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,502.14	1,808.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 ELMA G MILES PKWY
HINESVILLE,GA 31313-4000

PROVIDER NUMBER
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/17 THROUGH 11/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	308,908.93	ADJUSTMENTS	16,799.16
COVERED CHARGES	286,035.93	CONTRACTUAL ALLOW	189,243.20
NON-COVERD CHARGES	22,873.00	TOTAL MEDICAID LIAB	96,792.73
		LESS: COB	9,993.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	86,799.57

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	88	0	39,487.00	22,199.00
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	88	0	39,487.00	22,199.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	4,620.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	4,620.00	0.00
TOTAL ACCOMODATIONS	92	0	44,107.00	22,199.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,472.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,663.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,803.00	0.00	EDUCATION & TRAINING	150.00	0.00
RADIOLOGY-DIAGNOSTIC	5,000.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,033.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	860.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,226.00	0.00	MRI SERVICES	2,675.00	0.00
IV THERAPY	1,245.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,839.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	609.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,864.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,452.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	788.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	688.00	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	2,875.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	485.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	592.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,375.00	674.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,886.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,794.00	0.00			

TOTAL ANCILLARY	241,928.93	674.00
TOTAL ACCOMODATIONS	44,107.00	22,199.00
TOTAL CHARGES	286,035.93	22,873.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	594,582.30	ADJUSTMENTS	48,897.15
COVERED CHARGES	533,177.85	CONTRACTUAL ALLOW	311,284.63
NON-COVERD CHARGES	61,404.45	TOTAL MEDICAID LIAB	221,893.22
		LESS: COB	905.28
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	220,441.94
		ALL OTHER	195,957.80
		FEE SCHEDULE-LAB	23,765.30
		INJECTABLE DRUGS	718.84

TOTAL NUMBER OF CLAIMS 794

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,990.73	25.40	OTHER LAB	3,418.00	0.00
MED/SURG SUPPLY	767.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,149.50	2,750.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,435.00	22,526.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,513.00	3,473.00	FEE SCHEDULE LAB	134,625.50	13,610.00
EKG/ECG	12,545.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,699.50	376.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	577.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	180,611.50	2,984.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,494.79	12,627.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,580.00	737.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,309.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	828.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,006.00	497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,128.00	970.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,440.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,095.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,792.00	0.00			

TOTAL ANCILLARY	533,177.85	61,404.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	533,177.85	61,404.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	329.00	ADJUSTMENTS	0.00
COVERED CHARGES	319.00	CONTRACTUAL ALLOW	146.97
NON-COVERD CHARGES	10.00	TOTAL MEDICAID LIAB	172.03
		LESS: COB	172.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	319.00	10.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	319.00	10.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	319.00	10.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,480.19	ADJUSTMENTS	318.00
COVERED CHARGES	17,412.44	CONTRACTUAL ALLOW	15,292.44
NON-COVERD CHARGES	1,067.75	TOTAL MEDICAID LIAB	2,120.00
		LESS: COB	10.70
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	2,055.30
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332.44	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	544.00	402.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,783.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,498.00	198.00
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	13,124.00	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	131.00	467.25
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,412.44	1,067.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,412.44	1,067.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,068.25	ADJUSTMENTS	0.00
COVERED CHARGES	970.25	CONTRACTUAL ALLOW	469.54
NON-COVERD CHARGES	98.00	TOTAL MEDICAID LIAB	500.71
		LESS: COB	497.71
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.25	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	73.00	23.00
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	817.00	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	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	970.25	98.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	970.25	98.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,580,775.48	ADJUSTMENTS	0.00
COVERED CHARGES	1,580,775.48	CONTRACTUAL ALLOW	1,054,153.99
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	526,621.49
		LESS: COB	3,843.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	522,778.45

TOTAL NUMBER OF ADMISSIONS 61

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	144	0	83,520.00	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	144	0	83,520.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	95	0	92,435.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	95	0	92,435.00	0.00
TOTAL ACCOMODATIONS	239	0	175,955.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,930.13	0.00	OTHER LAB	690.00	0.00
MED/SURG SUPPLY	363,876.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	75,504.32	0.00	EDUCATION & TRAINING	397.00	0.00
RADIOLOGY-DIAGNOSTIC	18,902.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,287.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,837.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,812.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,186.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,998.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,174.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,887.10	0.00	INJECTABLE DRUGS	199.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,988.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	378.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	146,616.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,897.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,057.00	0.00			

TOTAL ANCILLARY	1,404,820.48	0.00
TOTAL ACCOMODATIONS	175,955.00	0.00
TOTAL CHARGES	1,580,775.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,364,483.18	ADJUSTMENTS	226,286.67
COVERED CHARGES	4,132,219.39	CONTRACTUAL ALLOW	3,384,649.58
NON-COVERD CHARGES	232,263.79	TOTAL MEDICAID LIAB	747,569.81
		LESS: COB	4,945.45
		LESS: COPAYMENT	1,446.00
		REIMBURSEMENT	741,178.36
		ALL OTHER	662,103.39
		FEE SCHEDULE-LAB	66,816.86
		INJECTABLE DRUGS	12,258.11

TOTAL NUMBER OF CLAIMS 2,049

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204,629.82	0.00	OTHER LAB	81,023.00	0.00
MED/SURG SUPPLY	293,635.01	34,785.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	537.00
RADIOLOGY-DIAGNOSTIC	203,272.00	247.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	606,417.00	61,186.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	459,191.68	19,103.32
EKG/ECG	86,803.00	1,572.00	MRI SERVICES	0.00	0.00
IV THERAPY	249,641.00	4,158.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	295,201.01	34,147.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,046.00	5,060.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,878.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,282,353.00	5,000.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,729.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	178,453.17	48,340.71
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,158.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,536.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,556.70	6,885.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,511.00	3,113.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,103.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,776.00	137.00			

TOTAL ANCILLARY	4,132,219.39	232,263.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,132,219.39	232,263.79

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,997.36	ADJUSTMENTS	0.00
COVERED CHARGES	29,684.62	CONTRACTUAL ALLOW	13,701.95
NON-COVERD CHARGES	8,312.74	TOTAL MEDICAID LIAB	15,982.67
		LESS: COB	15,967.67
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,944.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,264.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,136.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,208.60	80.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,575.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,430.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	242.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,920.00	513.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	920.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,980.27	153.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,079.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,684.62	8,312.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,684.62	8,312.74

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	91,856.61	ADJUSTMENTS	2,746.14
COVERED CHARGES	90,179.59	CONTRACTUAL ALLOW	83,377.07
NON-COVERD CHARGES	1,677.02	TOTAL MEDICAID LIAB	6,802.52
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	6,673.52
		TOTAL NUMBER OF CLAIMS	100

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,745.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,607.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,654.00	1,018.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,915.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,147.80	129.00
EKG/ECG	786.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,111.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,450.00	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	2,553.08	79.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	189.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	90,179.59	1,677.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,179.59	1,677.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,693.83	ADJUSTMENTS	0.00
COVERED CHARGES	2,673.83	CONTRACTUAL ALLOW	2,473.83
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	200.00
		LESS: COB	200.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	201.00	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	473.52	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	259.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	914.00	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	125.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,673.83	20.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,673.83	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	44,730,588.11	ADJUSTMENTS	1,122,134.87
COVERED CHARGES	43,101,238.60	CONTRACTUAL ALLOW	27,392,418.92
NON-COVERD CHARGES	1,629,349.51	TOTAL MEDICAID LIAB	15,708,819.68
		LESS: COB	217,336.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,491,483.67

TOTAL NUMBER OF ADMISSIONS 1,442

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6,459	0	4,233,220.00	282,754.00
ROUTINE NURSERY	1,036	0	744,674.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,495	0	4,977,894.00	282,754.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,129	0	1,963,331.00	0.00
NICU	363	0	762,300.00	0.00
PED ICU	59	0	102,601.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,551	0	2,828,232.00	0.00
TOTAL ACCOMODATIONS	9,046	0	7,806,126.00	282,754.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,176,159.74	0.00	OTHER LAB	152,091.07	0.00
MED/SURG SUPPLY	3,276,748.52	1,670.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,377,577.72	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	859,423.62	0.00	OTHER THERAPEUTIC SVC	0.00	13,739.20
CT SCAN	1,391,269.34	580,829.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	329,533.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	194,070.08	0.00	MRI SERVICES	726,116.07	0.00
IV THERAPY	198,869.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,014,957.75	8,925.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	854,828.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,518,109.07	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,247.42	0.00	AMBULANCE	0.00	52,354.98
GI SERVICES	499,500.00	6,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,095,401.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	284,818.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	121,636.54	0.00	INJECTABLE DRUGS	6,710,556.21	0.00
RADIOLOGY THERAPEUTIC	237,026.47	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180,005.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	134,124.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	213,594.80	2,512.88	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,632.08	8,674.60	TRAUMA RESPONSE	0.00	19,200.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	996,370.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	507,440.19	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	831,858.78	623,204.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,169.38	28,984.91			
AUDIOLOGY	68,324.00	0.00			
CARDIOLOGY	899,087.02	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	84,931.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,633.96	0.00			

TOTAL ANCILLARY	35,295,112.60	1,346,595.51
TOTAL ACCOMODATIONS	7,806,126.00	282,754.00
TOTAL CHARGES	43,101,238.60	1,629,349.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	324,133.23	ADJUSTMENTS	0.00
COVERED CHARGES	309,406.90	CONTRACTUAL ALLOW	145,297.73
NON-COVERD CHARGES	14,726.33	TOTAL MEDICAID LIAB	164,109.17
		LESS: COB	164,109.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	21	0	13,776.00	930.00
ROUTINE NURSERY	48	0	39,280.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	69	0	53,056.50	930.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	21	0	44,100.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	44,100.00	0.00
TOTAL ACCOMODATIONS	90	0	97,156.50	930.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,259.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43,212.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,052.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,903.19	0.00	OTHER THERAPEUTIC SVC	0.00	226.24
CT SCAN	4,756.20	1,600.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	342.88	0.00	MRI SERVICES	6,089.92	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,052.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,420.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,812.62	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	974.80	0.00	AMBULANCE	0.00	3,077.29
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,682.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,590.30	0.00	INJECTABLE DRUGS	15,533.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	253.52	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	143.98	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,315.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,514.26	8,892.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	551.00	0.00			
CARDIOLOGY	1,570.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	218.64	0.00			

TOTAL ANCILLARY	212,250.40	13,796.33
TOTAL ACCOMODATIONS	97,156.50	930.00
TOTAL CHARGES	309,406.90	14,726.33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,764,897.08	ADJUSTMENTS	813,825.02
COVERED CHARGES	18,358,409.08	CONTRACTUAL ALLOW	12,402,239.44
NON-COVERD CHARGES	3,406,488.00	TOTAL MEDICAID LIAB	5,956,169.64
		LESS: COB	13,621.41
		LESS: COPAYMENT	20,097.00
		REIMBURSEMENT	5,922,451.23
		ALL OTHER	5,037,371.38
		FEE SCHEDULE-LAB	298,911.17
		INJECTABLE DRUGS	586,168.68

TOTAL NUMBER OF CLAIMS 13,853

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230,054.97	2,871.15	OTHER LAB	72,540.75	0.00
MED/SURG SUPPLY	239,510.13	10,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	617,647.89	150,572.58	OTHER THERAPEUTIC SVC	0.00	7,996.40
CT SCAN	1,578,648.32	250,664.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,659.78	4,536.34	FEE SCHEDULE LAB	2,425,590.97	117,628.39
EKG/ECG	173,377.16	0.00	MRI SERVICES	267,879.28	14,870.16
IV THERAPY	1,353,229.80	65,328.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	591,177.97	391,754.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,207.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177,537.17	9,277.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,997.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	450,500.00	97,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,132,687.32	35,513.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	269,712.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,102,194.98	1,560,062.87
RADIOLOGY THERAPEUTIC	1,017,571.16	320,129.51	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,385.32	1,057.56	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,570.59	8,008.17	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	628.22	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	474,365.85	85,036.18	TRAUMA RESPONSE	0.00	6,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,432.57	12,336.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,691.00
OTHER IMAGING SERVICE	458,240.44	50,990.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	110,751.00	85,622.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,247.08	63,961.28			
AUDIOLOGY	61.00	551.00			
CARDIOLOGY	95,636.00	46,539.80			
AMBULATORY SURGERY	6,869.68	462.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,101.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	150,022.92	4,739.73			

TOTAL ANCILLARY	18,358,409.08	3,406,488.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,358,409.08	3,406,488.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	5918151002210	04/09/18 - 04/09/18	06/04/18	0.00	1,691.00	0.00	0.00	0.00
TOTAL				0.00	1,691.00	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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	379,176.30	ADJUSTMENTS	0.00
COVERED CHARGES	217,235.25	CONTRACTUAL ALLOW	78,731.86
NON-COVERD CHARGES	161,941.05	TOTAL MEDICAID LIAB	138,503.39
		LESS: COB	138,312.82
		LESS: COPAYMENT	190.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 149

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,181.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,097.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,052.34	3,071.00	OTHER THERAPEUTIC SVC	0.00	2,518.00
CT SCAN	4,107.80	14,472.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,756.98	3,862.21
EKG/ECG	685.76	0.00	MRI SERVICES	0.00	2,978.13
IV THERAPY	23,031.30	203.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,485.34	4,970.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,071.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,464.48	228.48	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,383.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,500.00	15,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,314.50	1,656.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,927.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,040.22	95,773.09
RADIOLOGY THERAPEUTIC	21,794.41	6,250.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	150.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	224.40	2,017.30	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,163.48	6,885.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,236.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	905.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,949.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,767.13	1,001.36			

TOTAL ANCILLARY	217,235.25	161,941.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,235.25	161,941.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	459,207.44	ADJUSTMENTS	768.16
COVERED CHARGES	440,222.87	CONTRACTUAL ALLOW	405,596.01
NON-COVERD CHARGES	18,984.57	TOTAL MEDICAID LIAB	34,626.86
		LESS: COB	34.40
		LESS: COPAYMENT	681.00
		REIMBURSEMENT	33,911.46
		TOTAL NUMBER OF CLAIMS	619

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,401.40	0.00	OTHER LAB	451.00	0.00
MED/SURG SUPPLY	325.54	254.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,830.91	5,136.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,084.15	2,585.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,071.56	1,400.91
EKG/ECG	4,286.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,647.00	406.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,318.00	351.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	188.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,692.10	414.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,487.45	3,720.50
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	135.04	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,290.34	1,676.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,120.75	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,372.75	682.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	655.92	0.00			

TOTAL ANCILLARY	440,222.87	18,984.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	440,222.87	18,984.57

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	23,102.94	ADJUSTMENTS	0.00
COVERED CHARGES	21,780.44	CONTRACTUAL ALLOW	15,483.29
NON-COVERD CHARGES	1,322.50	TOTAL MEDICAID LIAB	6,297.15
		LESS: COB	6,291.15
		LESS: COPAYMENT	6.00
		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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	277.00	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	3,337.35	126.91
EKG/ECG	342.88	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,592.87	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	353.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,213.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,548.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	805.15	207.65
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	539.00	987.94			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	380.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,780.44	1,322.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,780.44	1,322.50

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,184,654.55	ADJUSTMENTS	98,353.26
COVERED CHARGES	1,916,348.98	CONTRACTUAL ALLOW	1,372,741.44
NON-COVERD CHARGES	268,305.57	TOTAL MEDICAID LIAB	543,607.54
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	543,325.54
		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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,711.91	249.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110,614.14	573.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,261.33	32,567.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,632.55	5,170.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	578.14	FEE SCHEDULE LAB	20,933.38	1,373.31
EKG/ECG	1,371.52	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	52,112.70	406.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	372,292.96	42,699.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,699.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,972.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,492.60	828.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,205.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	678,176.73	55,700.96
RADIOLOGY THERAPEUTIC	72,262.49	500.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,268.32	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	360,588.20	107,416.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,340.57	1,481.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,628.25	3,672.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,211.04			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	707.30	8,610.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,345.47	0.00			

TOTAL ANCILLARY	1,916,348.98	268,305.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,916,348.98	268,305.57

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	160,295,093.56	ADJUSTMENTS	1,854,006.87
COVERED CHARGES	154,776,555.30	CONTRACTUAL ALLOW	118,420,146.86
NON-COVERD CHARGES	5,518,538.26	TOTAL MEDICAID LIAB	36,356,408.44
		LESS: COB	497,056.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,859,351.70

TOTAL NUMBER OF ADMISSIONS 2,596

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13,527	0	11,953,435.00	638,408.00
ROUTINE NURSERY	2,203	0	6,893,947.00	483,626.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15,730	0	18,847,382.00	1,122,034.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,946	0	11,030,593.00	253,873.00
NICU	164	0	1,002,035.00	0.00
PED ICU	1,144	0	3,774,711.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,254	0	15,807,339.00	253,873.00
TOTAL ACCOMODATIONS	20,984	0	34,654,721.00	1,375,907.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,754,571.11	396,592.02	OTHER LAB	857,115.00	13,494.00
MED/SURG SUPPLY	5,076,712.50	166,348.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,171,639.36	252,826.00	EDUCATION & TRAINING	89.00	0.00
RADIOLOGY-DIAGNOSTIC	3,549,171.00	30,916.00	OTHER THERAPEUTIC SVC	0.00	288,449.00
CT SCAN	6,361,957.00	159,812.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	850,892.10	13,162.18	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	553,909.00	2,491.00	MRI SERVICES	2,109,695.00	11,455.00
IV THERAPY	591,839.00	2,703.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,888,833.02	76,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,206,750.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,411,619.00	341,013.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,727,910.00	1,198.00	AMBULANCE	0.00	0.00
GI SERVICES	16,542.00	4,027.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,996,154.00	2,483.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,126,084.00	1,478.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	211,635.00	418.00	INJECTABLE DRUGS	8,168,103.96	157,854.86
RADIOLOGY THERAPEUTIC	22,867.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	306,203.65	2,498.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	278,855.27	5,143.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,270,777.00	1,907,863.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,077.00	44,395.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	45,633.00	0.00	IMPL DEV CHARGE PATIENTS	6,916,435.33	8,021.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	354.00
OTHER IMAGING SERVICE	426,504.00	3,774.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,896,175.00	83,134.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	569,532.00	68,400.00			
AUDIOLOGY	0.00	27,308.00			
CARDIOLOGY	3,945,335.00	8,737.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	198,777.00	3,609.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,612,442.00	56,304.00			

TOTAL ANCILLARY	120,121,834.30	4,142,631.26
TOTAL ACCOMODATIONS	34,654,721.00	1,375,907.00
TOTAL CHARGES	154,776,555.30	5,518,538.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2018169012970	12/23/17 - 12/28/17	06/25/18	0.00	354.00	0.00	0.00	0.00
TOTAL				0.00	354.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,138,604.31	ADJUSTMENTS	0.00
COVERED CHARGES	2,056,447.31	CONTRACTUAL ALLOW	506,425.19
NON-COVERD CHARGES	82,157.00	TOTAL MEDICAID LIAB	1,550,022.12
		LESS: COB	1,550,022.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	67	0	60,721.00	1,400.00
ROUTINE NURSERY	280	0	879,139.00	73,988.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	347	0	939,860.00	75,388.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	11	0	31,486.00	0.00
NICU	6	0	35,310.00	0.00
PED ICU	3	0	9,906.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	76,702.00	0.00
TOTAL ACCOMODATIONS	367	0	1,016,562.00	75,388.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	185,066.48	0.00	OTHER LAB	5,478.00	0.00
MED/SURG SUPPLY	69,209.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	144,790.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,841.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,050.00
CT SCAN	14,899.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,003.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,496.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,790.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,490.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	66,541.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	179,918.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,934.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,882.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,063.00	0.00	INJECTABLE DRUGS	30,754.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,879.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,014.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,292.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	211.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,476.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,314.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,498.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,916.00	865.00			
AUDIOLOGY	0.00	1,351.00			
CARDIOLOGY	39,808.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,491.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,964.00	0.00			

TOTAL ANCILLARY	1,039,885.31	6,769.00
TOTAL ACCOMODATIONS	1,016,562.00	75,388.00
TOTAL CHARGES	2,056,447.31	82,157.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,652,743.24	ADJUSTMENTS	1,262,304.87
COVERED CHARGES	45,731,207.12	CONTRACTUAL ALLOW	36,320,086.69
NON-COVERD CHARGES	6,921,536.12	TOTAL MEDICAID LIAB	9,411,120.43
		LESS: COB	46,213.54
		LESS: COPAYMENT	24,893.58
		REIMBURSEMENT	9,340,013.31
		ALL OTHER	7,756,574.67
		FEE SCHEDULE-LAB	887,992.62
		INJECTABLE DRUGS	695,446.02

TOTAL NUMBER OF CLAIMS 22,599

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,087,153.83	23,208.11	OTHER LAB	358,319.00	8,518.00
MED/SURG SUPPLY	740,916.00	77,676.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,136,389.00	145,432.00	OTHER THERAPEUTIC SVC	0.00	496.00
CT SCAN	3,852,383.00	691,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,678.00	24,256.36	FEE SCHEDULE LAB	9,716,039.16	416,517.71
EKG/ECG	385,997.00	9,164.00	MRI SERVICES	40,536.00	135,341.00
IV THERAPY	1,654,966.00	247,478.00	PROFESSIONAL FEES	0.00	84.00
OPERATING ROOM	4,764,185.25	973,487.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	128,655.00	51,450.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	269,126.00	85,557.00	FREE STANDING CLINIC	0.00	108.00
ANESTHESIA	1,202,055.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	90,932.67	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,334,065.84	79,608.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,486,604.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,710,031.37	1,084,775.34
RADIOLOGY THERAPEUTIC	213,181.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,792.00	9,983.54	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,474.00	8,774.45	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	94,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,944,644.00	318,029.37	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	180,053.00	1,669,648.00
LITHOTRIPSY	10,021.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	465,236.00	71,581.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	453,486.00	912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	536,665.00	125,841.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	437,820.00	311,713.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	153,957.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,246,846.00	255,130.00			

TOTAL ANCILLARY	45,731,207.12	6,921,536.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,731,207.12	6,921,536.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,087,754.92	ADJUSTMENTS	0.00
COVERED CHARGES	715,853.81	CONTRACTUAL ALLOW	288,969.93
NON-COVERD CHARGES	371,901.11	TOTAL MEDICAID LIAB	426,883.88
		LESS: COB	426,689.53
		LESS: COPAYMENT	194.35
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	286

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,851.17	16,789.97	OTHER LAB	1,770.00	0.00
MED/SURG SUPPLY	12,600.00	240.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,005.00	3,014.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,254.00	31,703.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,204.04	FEE SCHEDULE LAB	83,080.00	5,552.00
EKG/ECG	3,407.00	0.00	MRI SERVICES	4,628.00	19,836.00
IV THERAPY	24,880.00	4,108.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,387.40	81,323.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,974.00	3,868.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,790.00	2,004.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,347.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,069.00	93.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,281.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119,013.24	19,787.50
RADIOLOGY THERAPEUTIC	10,676.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	430.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,254.00	627.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,325.00	6,522.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,333.00	148,290.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,132.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,165.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,471.00	268.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	534.00	5,674.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,209.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,472.00	20,567.00			

TOTAL ANCILLARY	715,853.81	371,901.11
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	715,853.81	371,901.11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	819,333.50	ADJUSTMENTS	7,500.13
COVERED CHARGES	786,893.27	CONTRACTUAL ALLOW	753,429.68
NON-COVERD CHARGES	32,440.23	TOTAL MEDICAID LIAB	33,463.59
		LESS: COB	44.74
		LESS: COPAYMENT	1,020.00
		REIMBURSEMENT	32,398.85

TOTAL NUMBER OF CLAIMS 570

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,356.72	38.47	OTHER LAB	984.00	0.00
MED/SURG SUPPLY	535.00	274.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,462.00	8,089.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,113.00	10,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	180,445.00	7,249.00
EKG/ECG	8,392.00	192.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,899.00	558.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,990.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,716.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,628.00	1,089.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,856.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,164.55	1,292.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	627.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	428.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,143.00	702.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,862.00	1,379.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,919.00	0.00			

TOTAL ANCILLARY	786,893.27	32,440.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	786,893.27	32,440.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,362.19	ADJUSTMENTS	0.00
COVERED CHARGES	22,182.50	CONTRACTUAL ALLOW	8,117.57
NON-COVERD CHARGES	7,179.69	TOTAL MEDICAID LIAB	14,064.93
		LESS: COB	14,040.93
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.71	208.69	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	838.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,663.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,713.00	308.00
EKG/ECG	185.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,018.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,320.00	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	38.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,182.50	7,179.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,182.50	7,179.69

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

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,607,613.58	ADJUSTMENTS	138,731.30
COVERED CHARGES	10,805,776.86	CONTRACTUAL ALLOW	9,050,599.31
NON-COVERD CHARGES	1,801,836.72	TOTAL MEDICAID LIAB	1,755,177.55
		LESS: COB	0.00
		LESS: COPAYMENT	807.58
		REIMBURSEMENT	1,754,369.97

TOTAL NUMBER OF CLAIMS 291

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,871.80	3,588.77	OTHER LAB	44,482.00	3,646.00
MED/SURG SUPPLY	457,938.00	343,019.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	106,075.00	181,598.00	OTHER THERAPEUTIC SVC	0.00	51.00
CT SCAN	115,828.00	34,737.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	667.00	8,591.28	FEE SCHEDULE LAB	239,549.00	9,536.00
EKG/ECG	22,317.00	2,084.00	MRI SERVICES	19,154.00	6,205.00
IV THERAPY	63,343.00	20,187.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,315,545.90	125,096.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,934.00	6,206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,831.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,790.75	7,380.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,391.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,980,907.41	89,284.13
RADIOLOGY THERAPEUTIC	75,875.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	567.00	3,667.14	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	892.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,783.00	3,665.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	899,027.00	662,940.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,326.00	3,974.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,249.00	912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,573.00	22,074.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	373,137.00	109,119.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	855.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,374,760.00	153,384.00			

TOTAL ANCILLARY	10,805,776.86	1,801,836.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,805,776.86	1,801,836.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER, NAVICENT HEALTH (THE)
777 HEMLOCK ST
MACON,GA 31201-2102

PROVIDER NUMBER
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	270,448.42	ADJUSTMENTS	56,372.47
COVERED CHARGES	270,448.42	CONTRACTUAL ALLOW	100,426.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	170,022.42
		LESS: COB	904.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	169,117.51

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	23,040.00	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	72	0	23,040.00	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	72	0	23,040.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,723.72	0.00	OTHER LAB	2,047.00	0.00
MED/SURG SUPPLY	7,924.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,193.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,088.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,637.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,020.00	0.00	MRI SERVICES	1,164.00	0.00
IV THERAPY	1,220.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,984.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,228.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,362.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,595.00	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	250.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,173.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,374.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,482.00	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	2,406.00	0.00			

TOTAL ANCILLARY	247,408.42	0.00
TOTAL ACCOMODATIONS	23,040.00	0.00
TOTAL CHARGES	270,448.42	0.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL
610 SPARTA ROAD
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,707,654.32	ADJUSTMENTS	134,604.28
COVERED CHARGES	1,675,401.35	CONTRACTUAL ALLOW	1,176,870.07
NON-COVERD CHARGES	32,252.97	TOTAL MEDICAID LIAB	498,531.28
		LESS: COB	1,254.20
		LESS: COPAYMENT	1,272.00
		REIMBURSEMENT	496,005.08
		ALL OTHER	455,516.33
		FEE SCHEDULE-LAB	37,746.59
		INJECTABLE DRUGS	2,742.16

TOTAL NUMBER OF CLAIMS 1,186

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,209.53	26.45	OTHER LAB	13,835.00	0.00
MED/SURG SUPPLY	28,770.40	201.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	539.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,693.00	2,366.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,802.00	6,670.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,008.00	3,573.02	FEE SCHEDULE LAB	242,347.45	2,599.00
EKG/ECG	43,076.00	170.00	MRI SERVICES	28,012.00	0.00
IV THERAPY	102,035.00	952.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,302.00	2,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,463.00	1,322.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,203.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	491,883.00	1,184.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,300.97	1,938.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,552.00	1,668.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	597.00	1,065.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,342.00	1,834.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,395.00	713.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	42,613.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	41,051.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,055.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	85,856.00	2,818.00			

TOTAL ANCILLARY	1,675,401.35	32,252.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,675,401.35	32,252.97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,681.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,860.00	CONTRACTUAL ALLOW	1,143.11
NON-COVERD CHARGES	821.00	TOTAL MEDICAID LIAB	1,716.89
		LESS: COB	1,707.89
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	934.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	758.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	532.00	63.00
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	1,394.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,860.00	821.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,860.00	821.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,329.95	ADJUSTMENTS	2,652.16
COVERED CHARGES	160,708.20	CONTRACTUAL ALLOW	150,482.08
NON-COVERD CHARGES	2,621.75	TOTAL MEDICAID LIAB	10,226.12
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	9,857.12
		TOTAL NUMBER OF CLAIMS	172

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,375.30	14.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	454.50	70.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,467.00	290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,901.00	1,516.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,242.00	372.00
EKG/ECG	2,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,174.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	312.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,199.00	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	1,559.40	359.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	160,708.20	2,621.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	160,708.20	2,621.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,662.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,533.00	CONTRACTUAL ALLOW	657.00
NON-COVERD CHARGES	129.30	TOTAL MEDICAID LIAB	876.00
		LESS: COB	873.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	26.00	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	1,507.00	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	129.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,533.00	129.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,533.00	129.30

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,484.87	ADJUSTMENTS	5,545.23
COVERED CHARGES	39,446.17	CONTRACTUAL ALLOW	28,355.71
NON-COVERD CHARGES	38.70	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,090.46

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	404.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	355.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,124.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,114.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,632.00	21.00
EKG/ECG	850.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	683.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,955.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,190.60	17.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	322.00	0.00			

TOTAL ANCILLARY	39,446.17	38.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,446.17	38.70

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,937,345.85	ADJUSTMENTS	1,816,019.04
COVERED CHARGES	26,456,497.06	CONTRACTUAL ALLOW	19,802,570.02
NON-COVERD CHARGES	2,480,848.79	TOTAL MEDICAID LIAB	6,653,927.04
		LESS: COB	2,548.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,651,378.62

TOTAL NUMBER OF ADMISSIONS 632

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,024	0	1,837,603.40	1,427,622.64
ROUTINE NURSERY	76	0	67,610.00	15,710.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	534,105.15
TOTAL ROUTINE	2,100	0	1,905,213.40	1,977,437.79
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	926	0	2,484,227.00	24,960.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	926	0	2,484,227.00	24,960.00
TOTAL ACCOMODATIONS	3,026	0	4,389,440.40	2,002,397.79

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464,929.65	563.00	OTHER LAB	116,528.00	0.00
MED/SURG SUPPLY	896,518.24	13,051.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,183,599.00	5,100.00	EDUCATION & TRAINING	12,266.00	284.00
RADIOLOGY-DIAGNOSTIC	459,183.65	738.00	OTHER THERAPEUTIC SVC	0.00	23,876.00
CT SCAN	1,085,282.00	57,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	216,857.00	1,336.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	229,082.00	397.00	MRI SERVICES	181,061.00	0.00
IV THERAPY	132,139.00	1,664.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,180,107.00	14,978.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	117,965.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,715,469.30	103,125.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	612,346.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	326,856.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,753,606.50	5,474.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	84,955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	131,278.00	0.00	INJECTABLE DRUGS	3,346,163.32	8,379.00
RADIOLOGY THERAPEUTIC	13,138.00	3,594.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	85,188.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,259.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	252,066.00	12,804.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,342.00	3,770.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	211,150.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	240,453.00	16,062.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	231,350.00	193,533.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,992.00	12,353.00			
AUDIOLOGY	6,480.00	0.00			
CARDIOLOGY	1,442,437.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,941.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	159,069.00	0.00			

TOTAL ANCILLARY	22,067,056.66	478,451.00
TOTAL ACCOMODATIONS	4,389,440.40	2,002,397.79
TOTAL CHARGES	26,456,497.06	2,480,848.79

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 01/01/18 THROUGH 12/31/18
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	2019029079980	11/26/18 - 12/11/18	02/04/19	0.00	0.00	0.00	0.00	0.00
24	2019100071355	08/08/18 - 08/22/18	04/15/19	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,852,308.74	ADJUSTMENTS	104,618.57
COVERED CHARGES	16,770,292.15	CONTRACTUAL ALLOW	13,657,631.28
NON-COVERD CHARGES	2,082,016.59	TOTAL MEDICAID LIAB	3,112,660.87
		LESS: COB	1,470.85
		LESS: COPAYMENT	7,299.48
		REIMBURSEMENT	3,103,890.54
		ALL OTHER	2,900,805.16
		FEE SCHEDULE-LAB	176,107.12
		INJECTABLE DRUGS	26,978.26

TOTAL NUMBER OF CLAIMS 6,153

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	285,233.99	19,837.00	OTHER LAB	148,622.00	0.00
MED/SURG SUPPLY	259,937.85	6,523.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,584.00
RADIOLOGY-DIAGNOSTIC	824,508.90	29,486.00	OTHER THERAPEUTIC SVC	0.00	2,224.00
CT SCAN	1,464,329.50	290,908.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,542.00	5,614.00	FEE SCHEDULE LAB	1,822,890.45	185,443.77
EKG/ECG	248,014.00	1,205.00	MRI SERVICES	431,680.00	44,909.00
IV THERAPY	1,439,917.00	84,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,148,353.33	191,662.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	726.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,524.48	5,416.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	728,365.00	757.00	AMBULANCE	0.00	0.00
GI SERVICES	809,298.00	104,588.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,785,179.37	49,822.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	158,003.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	246,403.00	182,849.00
RADIOLOGY THERAPEUTIC	99,037.00	117,951.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,186.00	3,688.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	852.00	1,849.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,769.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,435.00	36,072.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,264.44	12,135.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	990,465.00	173,254.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,078.00	19,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	282,047.00	304,148.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	421,997.00	164,409.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	405,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215,512.84	30,372.00			

TOTAL ANCILLARY	16,770,292.15	2,082,016.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,770,292.15	2,082,016.59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,949.80	ADJUSTMENTS	0.00
COVERED CHARGES	89,333.80	CONTRACTUAL ALLOW	22,358.99
NON-COVERD CHARGES	95,616.00	TOTAL MEDICAID LIAB	66,974.81
		LESS: COB	66,927.52
		LESS: COPAYMENT	47.29
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,162.00	292.00	OTHER LAB	779.00	0.00
MED/SURG SUPPLY	1,178.80	231.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,029.00	369.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,676.00	9,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,435.00	647.00
EKG/ECG	728.00	0.00	MRI SERVICES	0.00	2,789.00
IV THERAPY	10,641.00	554.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	12,258.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,727.00	1,464.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,811.00	2,957.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	882.00	57,683.00
RADIOLOGY THERAPEUTIC	1,117.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,641.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,948.00	2,953.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,051.00	0.00			

TOTAL ANCILLARY	89,333.80	95,616.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	89,333.80	95,616.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,730,820.36	ADJUSTMENTS	16,327.66
COVERED CHARGES	1,582,207.64	CONTRACTUAL ALLOW	1,530,484.12
NON-COVERD CHARGES	148,612.72	TOTAL MEDICAID LIAB	51,723.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,584.00
		REIMBURSEMENT	50,139.52

TOTAL NUMBER OF CLAIMS 785

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,222.00	2,311.00	OTHER LAB	14,148.00	0.00
MED/SURG SUPPLY	3,755.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,750.24	11,528.72	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	135,902.00	107,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	175,148.00	5,820.00
EKG/ECG	16,482.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	91,619.00	790.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,707.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	989,817.00	1,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,920.00	2,934.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,377.00	16,314.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,360.00	688.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,582,207.64	148,612.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,582,207.64	148,612.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,064.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,908.00	CONTRACTUAL ALLOW	3,207.76
NON-COVERD CHARGES	156.00	TOTAL MEDICAID LIAB	1,700.24
		LESS: COB	1,697.24
		LESS: COPAYMENT	3.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	156.00	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	295.00	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	325.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,175.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	113.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,908.00	156.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,908.00	156.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,052,549.97	ADJUSTMENTS	0.00
COVERED CHARGES	1,016,291.47	CONTRACTUAL ALLOW	873,787.72
NON-COVERD CHARGES	36,258.50	TOTAL MEDICAID LIAB	142,503.75
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	142,425.75
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,619.00	172.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,927.97	635.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,617.00	1,437.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,706.00	3,179.00
EKG/ECG	993.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,079.00	247.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,514.50	3,417.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	794.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,928.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,058.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	712,705.00	26,235.00
RADIOLOGY THERAPEUTIC	3,674.00	936.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	2,697.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,290.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,924.00	0.00			

TOTAL ANCILLARY	1,016,291.47	36,258.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,016,291.47	36,258.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	384,013.64	ADJUSTMENTS	6,554.14
COVERED CHARGES	335,333.64	CONTRACTUAL ALLOW	200,217.76
NON-COVERD CHARGES	48,680.00	TOTAL MEDICAID LIAB	135,115.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	135,115.88

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	128	0	120,320.00	48,680.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	128	0	120,320.00	48,680.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	3,640.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	3,640.00	0.00
TOTAL ACCOMODATIONS	130	0	123,960.00	48,680.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,249.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,607.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,321.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,216.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,645.41	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,015.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,992.72	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	2,871.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,190.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	124.38	0.00	INJECTABLE DRUGS	86,896.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,228.32	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25.25	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,934.18	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,725.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	459.46	0.00			

TOTAL ANCILLARY	211,373.64	0.00
TOTAL ACCOMODATIONS	123,960.00	48,680.00
TOTAL CHARGES	335,333.64	48,680.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	515,361.06	ADJUSTMENTS	13,344.26
COVERED CHARGES	461,844.13	CONTRACTUAL ALLOW	389,021.75
NON-COVERD CHARGES	53,516.93	TOTAL MEDICAID LIAB	72,822.38
		LESS: COB	31.95
		LESS: COPAYMENT	579.00
		REIMBURSEMENT	72,211.43
		ALL OTHER	51,589.34
		FEE SCHEDULE-LAB	20,508.33
		INJECTABLE DRUGS	113.76

TOTAL NUMBER OF CLAIMS 644

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,104.58	0.00	OTHER LAB	44,226.56	0.00
MED/SURG SUPPLY	3,714.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,897.43	885.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,179.03	27,257.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,533.28	3,492.67	FEE SCHEDULE LAB	166,468.29	7,323.49
EKG/ECG	3,187.05	249.09	MRI SERVICES	0.00	0.00
IV THERAPY	9,272.87	2,888.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,523.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	574.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,470.03	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,400.00	1,200.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,235.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,006.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,756.72	1,676.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	438.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,163.63	474.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,835.45	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,351.62	5,450.54			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,943.64	2,180.10			

TOTAL ANCILLARY	461,844.13	53,516.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	461,844.13	53,516.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,193.48	ADJUSTMENTS	0.00
COVERED CHARGES	10,478.64	CONTRACTUAL ALLOW	4,922.56
NON-COVERD CHARGES	1,714.84	TOTAL MEDICAID LIAB	5,556.08
		LESS: COB	5,535.08
		LESS: COPAYMENT	21.00
		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

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,244.09	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	2,136.66	481.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.44	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	472.86	0.00	FREE STANDING CLINIC	0.00	0.00
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	593.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,212.44	869.74			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,115.45	363.35			

TOTAL ANCILLARY	10,478.64	1,714.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,478.64	1,714.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDICAL CENTER
706 N PARRISH AVE
ADEL,GA 31620-1511

PROVIDER NUMBER
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,093,036.03	ADJUSTMENTS	64,271.24
COVERED CHARGES	2,890,314.03	CONTRACTUAL ALLOW	1,871,950.82
NON-COVERD CHARGES	202,722.00	TOTAL MEDICAID LIAB	1,018,363.21
		LESS: COB	15,330.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,003,032.30

TOTAL NUMBER OF ADMISSIONS 165

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	399	0	264,210.00	118,865.00
ROUTINE NURSERY	55	0	30,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	454	0	295,010.00	118,865.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	142	0	186,020.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	142	0	186,020.00	0.00
TOTAL ACCOMODATIONS	596	0	481,030.00	118,865.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343,988.20	0.00	OTHER LAB	19,739.00	0.00
MED/SURG SUPPLY	187,949.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	507,395.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,601.00	0.00	OTHER THERAPEUTIC SVC	219.00	0.00
CT SCAN	159,896.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,146.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,254.00	0.00	MRI SERVICES	26,878.00	0.00
IV THERAPY	59,948.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,847.00	51,099.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	176,419.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	307,265.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,719.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,327.00	0.00	SPECIAL SERVICES	0.00	771.00
RECOVERY ROOM	18,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,673.00	0.00	INJECTABLE DRUGS	1,366.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,332.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	887.04	1,019.00	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	NO CC/INVALID REV CODE	0.00	2,648.00
OTHER IMAGING SERVICE	6,006.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,541.00	28,320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,984.00	0.00			
AUDIOLOGY	9,636.00	0.00			
CARDIOLOGY	22,544.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,189.00	0.00			

TOTAL ANCILLARY	2,409,284.03	83,857.00
TOTAL ACCOMODATIONS	481,030.00	118,865.00
TOTAL CHARGES	2,890,314.03	202,722.00

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 04/01/17 THROUGH 03/31/18
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
31	2217283002161	09/26/17 - 09/28/17	10/16/17	0.00	110.00	0.00	0.00	0.00
615	2218003001693	07/21/17 - 07/24/17	01/08/18	0.00	2,434.00	0.00	0.00	0.00
308	2218024004195	12/18/17 - 12/20/17	01/29/18	0.00	104.00	0.00	0.00	0.00
TOTAL				0.00	2,648.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL 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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,568.50	ADJUSTMENTS	0.00
COVERED CHARGES	8,568.50	CONTRACTUAL ALLOW	2,942.86
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,625.64
		LESS: COB	5,625.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	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	2	0	2,620.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	2,620.00	0.00
TOTAL ACCOMODATIONS	2	0	2,620.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	850.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,828.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,876.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	308.00	0.00			

TOTAL ANCILLARY	5,948.50	0.00
TOTAL ACCOMODATIONS	2,620.00	0.00
TOTAL CHARGES	8,568.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,153,519.19	ADJUSTMENTS	186,619.00
COVERED CHARGES	4,733,322.18	CONTRACTUAL ALLOW	3,765,026.57
NON-COVERD CHARGES	420,197.01	TOTAL MEDICAID LIAB	968,295.61
		LESS: COB	3,398.95
		LESS: COPAYMENT	2,292.42
		REIMBURSEMENT	962,604.24
		ALL OTHER	813,877.90
		FEE SCHEDULE-LAB	143,927.31
		INJECTABLE DRUGS	4,799.03

TOTAL NUMBER OF CLAIMS 3,053

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135,336.90	9,147.65	OTHER LAB	94,948.00	475.00
MED/SURG SUPPLY	172,076.40	2,185.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,471.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,119.00	10,184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	626,460.00	91,956.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,015.00	8,735.00	FEE SCHEDULE LAB	1,126,833.00	64,289.00
EKG/ECG	66,064.00	6,408.00	MRI SERVICES	67,496.00	16,936.00
IV THERAPY	258,014.00	29,129.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	351,624.00	33,991.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,359.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,115.00	69,200.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,028.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,150,975.00	8,908.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,705.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	119.00	INJECTABLE DRUGS	17,460.03	9,140.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,118.00	3,441.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,314.00	417.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,736.00	4,219.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,963.00	3,578.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,295.10
OTHER IMAGING SERVICE	72,108.00	7,556.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,964.00	11,800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,654.00	1,240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,045.00	5,636.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,791.00	10,741.00			

TOTAL ANCILLARY	4,733,322.18	420,197.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,733,322.18	420,197.01

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	5917207000708	05/04/17 - 05/04/17	07/31/17	0.00	2,918.00	0.00	0.00	0.00
616	5917207000708	05/04/17 - 05/04/17	07/31/17	0.00	1,946.00	0.00	0.00	0.00
615	2017215083023	07/24/17 - 07/24/17	08/07/17	0.00	1,217.00	0.00	0.00	0.00
615	2017215083023	07/24/17 - 07/24/17	08/07/17	0.00	1,946.00	0.00	0.00	0.00
3017	2217272002858	09/05/17 - 09/05/17	10/02/17	0.00	48.00	0.00	0.00	0.00
615	5918010002275	10/24/17 - 10/24/17	01/15/18	0.00	1,217.00	0.00	0.00	0.00
2500	2218239007572	11/19/17 - 11/19/17	09/03/18	0.00	3.10	0.00	0.00	0.00
TOTAL				0.00	9,295.10	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,127.55	ADJUSTMENTS	0.00
COVERED CHARGES	48,362.55	CONTRACTUAL ALLOW	25,932.17
NON-COVERD CHARGES	3,765.00	TOTAL MEDICAID LIAB	22,430.38
		LESS: COB	22,364.38
		LESS: COPAYMENT	66.00
		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

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,173.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,468.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,074.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,862.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,847.00	2,244.00	FEE SCHEDULE LAB	9,561.00	140.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,718.00	576.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,865.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	169.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,926.00	143.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,278.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	206.50	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	618.00	143.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	48,362.55	3,765.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,362.55	3,765.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	186,919.20	ADJUSTMENTS	538.40
COVERED CHARGES	177,445.70	CONTRACTUAL ALLOW	167,488.38
NON-COVERD CHARGES	9,473.50	TOTAL MEDICAID LIAB	9,957.32
		LESS: COB	46.02
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	9,614.30
		TOTAL NUMBER OF CLAIMS	178

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,017.40	28.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,246.00	416.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,753.00	490.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,983.00	3,731.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,678.00	2,876.00
EKG/ECG	1,081.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,511.00	312.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,131.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,213.00	805.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	313.30	153.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	143.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	519.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	177,445.70	9,473.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	177,445.70	9,473.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR
1500 E SHOTWELL ST
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	138,900,749.04	ADJUSTMENTS	1,284,343.31
COVERED CHARGES	129,084,242.29	CONTRACTUAL ALLOW	93,860,212.44
NON-COVERD CHARGES	9,816,506.75	TOTAL MEDICAID LIAB	35,224,029.85
		LESS: COB	178,390.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	35,045,639.30

TOTAL NUMBER OF ADMISSIONS 2,734

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,847	0	12,032,510.40	6,683,326.68
ROUTINE NURSERY	2,055	0	4,645,041.75	518,029.75
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	434,905.81
TOTAL ROUTINE	14,902	0	16,677,552.15	7,636,262.24
SPECIAL CARE SERVICES				
CCU	243	0	1,013,183.25	0.00
ICU	3,894	0	10,501,811.50	0.00
NICU	135	0	591,775.50	0.00
PED ICU	495	0	2,703,049.50	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	357	0	1,678,719.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,124	0	16,488,538.75	0.00
TOTAL ACCOMODATIONS	20,026	0	33,166,090.90	7,636,262.24

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,422,502.49	105.59	OTHER LAB	536,744.22	0.00
MED/SURG SUPPLY	8,110,786.45	4,565.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,320,442.85	2,393.04	EDUCATION & TRAINING	19,653.12	0.00
RADIOLOGY-DIAGNOSTIC	3,123,098.57	0.00	OTHER THERAPEUTIC SVC	0.00	1,677.56
CT SCAN	2,712,699.21	578,580.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,193,650.76	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	452,703.58	0.00	MRI SERVICES	1,174,325.19	0.00
IV THERAPY	748,773.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,913,557.99	124,185.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	882,649.17	0.00	REHAB THERAPY	16,351.92	0.00
RESPIRATORY SERVICES	7,540,652.57	9,884.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,605,334.97	0.00	AMBULANCE	0.00	0.00
GI SERVICES	284,796.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,940,198.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,510,014.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	92,434.42
LABORATORY PATHOLOGIC	258,291.52	0.00	INJECTABLE DRUGS	11,156,007.08	86.29
RADIOLOGY THERAPEUTIC	615,443.96	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	741,364.56	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	369,889.95	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	425,038.60	586,611.27	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	33,220.09	6,617.02	TRAUMA RESPONSE	0.00	698,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,817,712.39	0.02
LITHOTRIPSY	18,353.75	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	815,548.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,379,569.72	73,237.91			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	354,039.50	715.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,927,457.32	750.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	152,686.87	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	344,591.94	0.00			

TOTAL ANCILLARY	95,918,151.39	2,180,244.51
TOTAL ACCOMODATIONS	33,166,090.90	7,636,262.24
TOTAL CHARGES	129,084,242.29	9,816,506.75

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,349,408.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,268,086.75	CONTRACTUAL ALLOW	749,520.56
NON-COVERD CHARGES	81,321.25	TOTAL MEDICAID LIAB	518,566.19
		LESS: COB	518,566.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	70	0	63,992.00	35,684.00
ROUTINE NURSERY	122	0	267,110.00	41,362.25
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	192	0	331,102.00	77,046.25
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	16	0	78,920.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	78,920.00	0.00
TOTAL ACCOMODATIONS	208	0	410,022.00	77,046.25

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,816.14	0.00	OTHER LAB	950.82	0.00
MED/SURG SUPPLY	116,185.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	86,516.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,635.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,957.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,159.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	126,362.29	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,273.76	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	185,774.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,574.49	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,513.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,449.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,655.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	831.27	0.00	INJECTABLE DRUGS	57,422.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,828.69	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	590.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,777.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,079.91	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,022.50	4,275.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,988.84	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,697.43	0.00			

TOTAL ANCILLARY	858,064.75	4,275.00
TOTAL ACCOMODATIONS	410,022.00	77,046.25
TOTAL CHARGES	1,268,086.75	81,321.25

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,174,742.29	ADJUSTMENTS	388,340.20
COVERED CHARGES	30,271,401.97	CONTRACTUAL ALLOW	25,506,397.05
NON-COVERD CHARGES	5,903,340.32	TOTAL MEDICAID LIAB	4,765,004.92
		LESS: COB	24,418.87
		LESS: COPAYMENT	9,287.20
		REIMBURSEMENT	4,731,298.85
		ALL OTHER	4,397,698.27
		FEE SCHEDULE-LAB	333,600.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9,603

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,379.13	17.50	OTHER LAB	675,361.46	3,083.75
MED/SURG SUPPLY	964,546.10	249,023.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	3,025.94
RADIOLOGY-DIAGNOSTIC	1,615,149.01	124,601.31	OTHER THERAPEUTIC SVC	0.00	1,684.28
CT SCAN	2,111,504.77	570,754.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	119,201.33	69,821.83	FEE SCHEDULE LAB	3,171,256.32	284,298.78
EKG/ECG	313,466.21	678.75	MRI SERVICES	776,868.14	156,057.09
IV THERAPY	1,058,657.19	20,591.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,972,108.37	1,383,059.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,669.47	5,371.43	REHAB THERAPY	0.00	585.00
RESPIRATORY SERVICES	170,227.76	638.47	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,834,763.03	0.00	AMBULANCE	0.00	0.00
GI SERVICES	292,037.85	175,801.57	CAST ROOM	1,794.00	0.00
EMERGENCY ROOM	9,023,950.77	32,623.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	774,623.99	0.00	DRUG-SPECIFIC/HOME IV	0.00	650.01
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	1,197,141.26	1,417,068.60	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,616.26	45,689.51	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,104.48	27,016.56	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,748.41	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120,727.01	43,751.55	TRAUMA RESPONSE	0.00	346,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,551.42	229,839.17
LITHOTRIPSY	22,795.35	0.00	NO CC/INVALID REV CODE	0.00	3,466.34
OTHER IMAGING SERVICE	704,008.80	157,346.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,446.10	247.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	488,394.53	147,844.59			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	196,646.49	366,685.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,128.89	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	645,276.48	28,268.53			

TOTAL ANCILLARY	30,271,401.97	5,903,340.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,271,401.97	5,903,340.32

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 02/01/18 THROUGH 01/31/19
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	2018180066765	02/01/18 - 02/01/18	07/09/18	0.00	2,897.34	0.00	0.00	0.00
614	2018180066765	02/01/18 - 02/01/18	07/09/18	0.00	569.00	0.00	0.00	0.00
TOTAL				0.00	3,466.34	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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	792,998.44	ADJUSTMENTS	0.00
COVERED CHARGES	472,804.37	CONTRACTUAL ALLOW	273,687.83
NON-COVERD CHARGES	320,194.07	TOTAL MEDICAID LIAB	199,116.54
		LESS: COB	199,063.51
		LESS: COPAYMENT	53.03
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 143

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,854.43	0.00	OTHER LAB	17,821.63	0.00
MED/SURG SUPPLY	18,994.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,993.67	1,318.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,834.31	29,995.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,441.59	2,320.82
EKG/ECG	690.00	230.00	MRI SERVICES	3,621.68	53,369.49
IV THERAPY	9,023.13	3,425.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,056.86	53,925.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,221.25	1,535.43	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,836.62	877.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,497.57	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,983.24	2,753.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,242.93	6,957.31	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,257.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	8,749.35	371.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,339.52	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,239.53	312.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	958.70	98,503.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,328.82	49,734.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,719.12	5,588.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,272.80	7,590.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,165.09	46.05			

TOTAL ANCILLARY	472,804.37	320,194.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	472,804.37	320,194.07

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,210,630.30	ADJUSTMENTS	22,674.73
COVERED CHARGES	1,196,246.89	CONTRACTUAL ALLOW	1,145,597.69
NON-COVERD CHARGES	14,383.41	TOTAL MEDICAID LIAB	50,649.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,299.00
		REIMBURSEMENT	49,350.20
		TOTAL NUMBER OF CLAIMS	793

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,471.11	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,381.60	335.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,429.82	2,402.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,834.70	8,187.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	503.01	594.60	FEE SCHEDULE LAB	81,724.90	1,406.71
EKG/ECG	8,495.74	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,598.50	226.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,476.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,497.64	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	931,518.55	945.65	SPECIAL SERVICES	0.00	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	1,929.35	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,209.16	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,176.56	0.00			

TOTAL ANCILLARY	1,196,246.89	14,383.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,196,246.89	14,383.41

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	54,771.25	ADJUSTMENTS	0.00
COVERED CHARGES	42,932.27	CONTRACTUAL ALLOW	30,918.32
NON-COVERD CHARGES	11,838.98	TOTAL MEDICAID LIAB	12,013.95
		LESS: COB	12,001.95
		LESS: COPAYMENT	12.00
		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

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204.55	62.15	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	367.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,886.22	318.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,756.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,529.16	1,656.25
EKG/ECG	285.66	230.00	MRI SERVICES	0.00	0.00
IV THERAPY	910.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.50	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	25,469.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,021.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,550.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,045.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,105.20	0.00			

TOTAL ANCILLARY	42,932.27	11,838.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,932.27	11,838.98

GEORGIA 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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,501,947.69	ADJUSTMENTS	24,798.84
COVERED CHARGES	4,448,763.71	CONTRACTUAL ALLOW	4,082,687.58
NON-COVERD CHARGES	1,053,183.98	TOTAL MEDICAID LIAB	366,076.13
		LESS: COB	0.00
		LESS: COPAYMENT	543.50
		REIMBURSEMENT	365,532.63
		TOTAL NUMBER OF CLAIMS	59

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,551.19	0.00	OTHER LAB	3,077.69	0.00
MED/SURG SUPPLY	280,694.33	129,546.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,749.98	43,589.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	257.50	1,034.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,481.27	FEE SCHEDULE LAB	28,383.56	8,061.45
EKG/ECG	2,570.48	0.00	MRI SERVICES	0.00	6,091.02
IV THERAPY	6,072.69	195.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	955,462.19	82,855.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	390.00
RESPIRATORY SERVICES	560.00	41.69	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	210,263.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,569.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,432.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	615,355.54	5,668.80	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,145.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	663.55	2,965.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,988,455.59	446,969.13
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,996.85	1,021.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,430.87	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,241.29	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,913.75	319,573.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,059.82	1,554.75			

TOTAL ANCILLARY	4,448,763.71	1,053,183.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,448,763.71	1,053,183.98

GEORGIA DEPARTMENT OF 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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	89,999.21	ADJUSTMENTS	0.00
COVERED CHARGES	83,130.46	CONTRACTUAL ALLOW	52,637.94
NON-COVERD CHARGES	6,868.75	TOTAL MEDICAID LIAB	30,492.52
		LESS: COB	30,489.52
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 02/01/18 THROUGH 01/31/19
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	620.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	389.59	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	6,868.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,340.00	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	1,498.75	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	77,281.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	83,130.46	6,868.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	83,130.46	6,868.75

** 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	112,187.37	ADJUSTMENTS	0.00
COVERED CHARGES	111,319.37	CONTRACTUAL ALLOW	45,196.02
NON-COVERD CHARGES	868.00	TOTAL MEDICAID LIAB	66,123.35
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	66,123.35

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	50	0	26,000.00	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	50	0	26,000.00	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	50	0	26,000.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,120.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,200.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,043.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,754.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,441.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,793.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,096.00	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	378.08	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,809.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,250.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,309.53	0.00	INJECTABLE DRUGS	16,457.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,345.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	849.00	0.00			
BLOOD	2,418.00	0.00			
BLOOD STORAGE & PRO.	930.84	868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,125.00	0.00			

TOTAL ANCILLARY	85,319.37	868.00
TOTAL ACCOMODATIONS	26,000.00	0.00
TOTAL CHARGES	111,319.37	868.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	567,096.35	ADJUSTMENTS	3,390.14
COVERED CHARGES	501,645.72	CONTRACTUAL ALLOW	339,476.25
NON-COVERD CHARGES	65,450.63	TOTAL MEDICAID LIAB	162,169.47
		LESS: COB	421.01
		LESS: COPAYMENT	328.08
		REIMBURSEMENT	161,420.38
		ALL OTHER	148,101.46
		FEE SCHEDULE-LAB	11,357.55
		INJECTABLE DRUGS	1,961.37

TOTAL NUMBER OF CLAIMS 537

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,387.00	6,977.00	OTHER LAB	5,407.00	0.00
MED/SURG SUPPLY	6,348.07	544.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,562.00	8,710.00	OTHER THERAPEUTIC SVC	0.00	11,439.20
CT SCAN	51,579.00	3,639.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,608.59	9,472.00
EKG/ECG	13,362.00	2,882.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,679.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,594.00	3,572.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,816.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,570.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	237,906.75	992.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,805.00	7,554.25
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	630.35	90.05	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,794.00	656.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	452.00			
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	10,596.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	4,700.00			

TOTAL ANCILLARY	501,645.72	65,450.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	501,645.72	65,450.63

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,496.27	ADJUSTMENTS	0.00
COVERED CHARGES	1,307.00	CONTRACTUAL ALLOW	310.91
NON-COVERD CHARGES	189.27	TOTAL MEDICAID LIAB	996.09
		LESS: COB	996.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	21.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4.00	50.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	110.00	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	1,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	8.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,307.00	189.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,307.00	189.27

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,647.06	ADJUSTMENTS	1,346.00
COVERED CHARGES	37,320.06	CONTRACTUAL ALLOW	34,600.06
NON-COVERD CHARGES	3,327.00	TOTAL MEDICAID LIAB	2,720.00
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	2,609.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94.00	328.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	286.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	328.00
CT SCAN	2,266.00	1,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,000.00	532.00
EKG/ECG	524.00	262.00	MRI SERVICES	0.00	0.00
IV THERAPY	322.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	28,300.60	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	809.00	480.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	184.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	37,320.06	3,327.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,320.06	3,327.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	846.50	ADJUSTMENTS	0.00
COVERED CHARGES	770.00	CONTRACTUAL ALLOW	698.28
NON-COVERD CHARGES	76.50	TOTAL MEDICAID LIAB	71.72
		LESS: COB	71.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	170.00	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	600.00	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	76.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	770.00	76.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	770.00	76.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,519,155.09	ADJUSTMENTS	19,026.11
COVERED CHARGES	2,487,795.09	CONTRACTUAL ALLOW	1,440,309.01
NON-COVERD CHARGES	31,360.00	TOTAL MEDICAID LIAB	1,047,486.08
		LESS: COB	897.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,046,588.58

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	544	0	209,055.00	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	544	0	209,055.00	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	544	0	209,055.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840,637.19	0.00	OTHER LAB	7,343.00	0.00
MED/SURG SUPPLY	426,760.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	362,360.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	103,163.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,760.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,649.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,456.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,523.00	12,800.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	173,082.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,813.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,036.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	450.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,159.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,275.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,713.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,150.00	18,560.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,303.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	65,121.00	0.00			

TOTAL ANCILLARY	2,278,740.09	31,360.00
TOTAL ACCOMODATIONS	209,055.00	0.00
TOTAL CHARGES	2,487,795.09	31,360.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,080,454.88	ADJUSTMENTS	113,107.97
COVERED CHARGES	6,130,259.28	CONTRACTUAL ALLOW	3,970,008.44
NON-COVERD CHARGES	950,195.60	TOTAL MEDICAID LIAB	2,160,250.84
		LESS: COB	54.15
		LESS: COPAYMENT	1,419.00
		REIMBURSEMENT	2,158,777.69
		ALL OTHER	1,925,061.54
		FEE SCHEDULE-LAB	233,529.56
		INJECTABLE DRUGS	186.59

TOTAL NUMBER OF CLAIMS 8,976

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,584.73	129,700.69	OTHER LAB	54,887.00	0.00
MED/SURG SUPPLY	597,659.65	8,878.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	898.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	376,739.00	17,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	329,207.00	50,922.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,432.00	210.00	FEE SCHEDULE LAB	1,529,949.60	299,978.00
EKG/ECG	14,993.00	981.00	MRI SERVICES	11,374.00	0.00
IV THERAPY	30,485.00	7,110.00	PROFESSIONAL FEES	0.00	769.00
OPERATING ROOM	610,940.00	82,139.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,589.00	5,971.00	FREE STANDING CLINIC	115.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,255.00	21,335.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	269,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	448.30	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	2,826.00	628.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,632.00	131.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,073.00	1,479.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	81,676.00	31,186.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,755.00	2,749.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,624,389.00	287,889.00			

TOTAL ANCILLARY	6,130,259.28	950,195.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,130,259.28	950,195.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,369.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,335.10	CONTRACTUAL ALLOW	2,090.58
NON-COVERD CHARGES	6,033.90	TOTAL MEDICAID LIAB	10,244.52
		LESS: COB	10,244.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254.90	423.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	659.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,070.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,488.00	1,586.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	1,936.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,650.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	17.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	308.00	438.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	12,335.10	6,033.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,335.10	6,033.90

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,199.95	ADJUSTMENTS	0.00
COVERED CHARGES	73,238.00	CONTRACTUAL ALLOW	68,860.00
NON-COVERD CHARGES	8,961.95	TOTAL MEDICAID LIAB	4,378.00
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	4,210.00
		TOTAL NUMBER OF CLAIMS	98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,691.75	2,229.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,946.25	83.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,492.00	145.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,902.00	1,528.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,689.00	1,856.00
EKG/ECG	218.00	109.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,214.00	546.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,600.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,460.00	819.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	949.00	1,646.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	73,238.00	8,961.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,238.00	8,961.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	273.00	ADJUSTMENTS	0.00
COVERED CHARGES	273.00	CONTRACTUAL ALLOW	85.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	187.28
		LESS: COB	184.28
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	273.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	273.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	273.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	82,280.05	ADJUSTMENTS	14,863.23
COVERED CHARGES	75,459.85	CONTRACTUAL ALLOW	50,677.80
NON-COVERD CHARGES	6,820.20	TOTAL MEDICAID LIAB	24,782.05
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	24,776.05
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,042.40	1,698.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,464.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	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	3,893.00	2,317.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,028.00	1,035.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,100.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,050.00	448.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41.00	394.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,750.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,457.00	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	33,344.00	0.00			

TOTAL ANCILLARY	75,459.85	6,820.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	75,459.85	6,820.20

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	499,111.61	ADJUSTMENTS	0.00
COVERED CHARGES	466,591.61	CONTRACTUAL ALLOW	226,329.20
NON-COVERD CHARGES	32,520.00	TOTAL MEDICAID LIAB	240,262.41
		LESS: COB	6,059.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	234,203.02

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	147	0	151,410.00	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	147	0	151,410.00	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	147	0	151,410.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,596.70	0.00	OTHER LAB	3,473.00	0.00
MED/SURG SUPPLY	6,083.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,623.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,085.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,160.00	29,366.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,828.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,682.00	0.00	MRI SERVICES	2,462.00	0.00
IV THERAPY	14,473.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,262.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,090.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,878.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,521.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,076.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	615.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66.00	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	NO CC/INVALID REV CODE	0.00	2,531.00
OTHER IMAGING SERVICE	374.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,860.00	623.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,704.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	783.00	0.00			

TOTAL ANCILLARY	315,181.61	32,520.00
TOTAL ACCOMODATIONS	151,410.00	0.00
TOTAL CHARGES	466,591.61	32,520.00

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 07/01/17 THROUGH 06/30/18
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	2017248098684	08/20/17 - 08/22/17	09/11/17	0.00	2,531.00	0.00	0.00	0.00
TOTAL				0.00	2,531.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,466,061.60	ADJUSTMENTS	59,222.93
COVERED CHARGES	2,259,889.10	CONTRACTUAL ALLOW	1,704,898.35
NON-COVERD CHARGES	206,172.50	TOTAL MEDICAID LIAB	554,990.75
		LESS: COB	502.72
		LESS: COPAYMENT	1,152.00
		REIMBURSEMENT	553,336.03
		ALL OTHER	488,356.91
		FEE SCHEDULE-LAB	54,615.16
		INJECTABLE DRUGS	10,363.96

TOTAL NUMBER OF CLAIMS 1,582

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,181.28	0.00	OTHER LAB	18,038.00	0.00
MED/SURG SUPPLY	15,731.00	2,888.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,564.00	3,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	356,188.00	38,074.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,528.00	6,415.00	FEE SCHEDULE LAB	419,450.00	29,666.00
EKG/ECG	28,757.00	2,086.00	MRI SERVICES	114,621.00	10,652.00
IV THERAPY	132,793.00	25,022.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,447.00	16,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,541.00	1,544.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,917.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	513,963.00	7,632.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,889.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	176,896.82	24,833.50
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	427.00	279.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	792.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,588.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,355.00	5,733.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,776.00	13,706.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,658.00	10,344.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,686.00	4,278.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,201.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,281.00	0.00			

TOTAL ANCILLARY	2,259,889.10	206,172.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,259,889.10	206,172.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,005.65	ADJUSTMENTS	0.00
COVERED CHARGES	25,624.65	CONTRACTUAL ALLOW	14,310.81
NON-COVERD CHARGES	7,381.00	TOTAL MEDICAID LIAB	11,313.84
		LESS: COB	11,310.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	584.60	0.00	OTHER LAB	481.00	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	1,126.00	907.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,790.00	3,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,895.00	85.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,525.00	64.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,622.00	564.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	863.05	412.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,010.00	2,205.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	25,624.65	7,381.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,624.65	7,381.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	119,073.95	ADJUSTMENTS	0.00
COVERED CHARGES	112,662.35	CONTRACTUAL ALLOW	104,162.35
NON-COVERD CHARGES	6,411.60	TOTAL MEDICAID LIAB	8,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	8,305.00
		TOTAL NUMBER OF CLAIMS	170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,403.16	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	6,370.00	548.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,640.00	3,144.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,009.00	FEE SCHEDULE LAB	22,106.00	377.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,126.00	451.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	396.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,222.00	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	6,456.19	424.60
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,496.00	458.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,662.35	6,411.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	112,662.35	6,411.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,227.35	ADJUSTMENTS	0.00
COVERED CHARGES	2,227.35	CONTRACTUAL ALLOW	1,402.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	824.75
		LESS: COB	824.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.35	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	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	588.00	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	1,617.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,227.35	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,227.35	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,749.45	ADJUSTMENTS	0.00
COVERED CHARGES	90,145.45	CONTRACTUAL ALLOW	80,174.57
NON-COVERD CHARGES	3,604.00	TOTAL MEDICAID LIAB	9,970.88
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	9,892.88

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,728.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,057.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	280.00	280.00	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	349.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,895.00	1,485.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,623.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,636.00	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	6,157.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,419.98	114.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,725.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	90,145.45	3,604.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,145.45	3,604.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,201.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,826.00	CONTRACTUAL ALLOW	7,484.51
NON-COVERD CHARGES	375.00	TOTAL MEDICAID LIAB	4,341.49
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,341.49

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	1,881.00	375.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,881.00	375.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,881.00	375.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,595.00	0.00	OTHER LAB	698.00	0.00
MED/SURG SUPPLY	164.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,207.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,662.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,346.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,945.00	0.00
TOTAL ACCOMODATIONS	1,881.00	375.00
TOTAL CHARGES	11,826.00	375.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,957,800.03	ADJUSTMENTS	76,101.14
COVERED CHARGES	1,860,213.00	CONTRACTUAL ALLOW	1,477,554.70
NON-COVERD CHARGES	97,587.03	TOTAL MEDICAID LIAB	382,658.30
		LESS: COB	0.00
		LESS: COPAYMENT	1,464.00
		REIMBURSEMENT	381,194.30
		ALL OTHER	321,031.89
		FEE SCHEDULE-LAB	56,348.16
		INJECTABLE DRUGS	3,814.25

TOTAL NUMBER OF CLAIMS 1,841

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	274,975.00	70.00	OTHER LAB	4,622.00	0.00
MED/SURG SUPPLY	16,309.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125,655.00	687.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	291,543.00	47,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,169.00	12,205.00	FEE SCHEDULE LAB	501,628.00	21,949.00
EKG/ECG	12,136.00	0.00	MRI SERVICES	10,966.00	0.00
IV THERAPY	19,242.00	1,523.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,218.00	2,368.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,719.00	5,681.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,491.00	3,140.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,194.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,584.00	595.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	539.00	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	NO CC/INVALID REV CODE	207.00	0.00
OTHER IMAGING SERVICE	35,105.00	965.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	504.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,836.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,110.00	0.00			

TOTAL ANCILLARY	1,860,213.00	97,587.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,860,213.00	97,587.03

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 10/01/17 THROUGH 09/30/18
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	2018108006816	04/11/18 - 04/11/18	04/23/18	69.00	0.00	0.00	0.00	20.52
780	2018128006450	05/01/18 - 05/01/18	05/14/18	69.00	0.00	0.00	0.00	20.52
780	2018128007068	05/01/18 - 05/01/18	05/14/18	69.00	0.00	0.00	0.00	20.52
TOTAL				207.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,078.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,629.00	CONTRACTUAL ALLOW	1,838.08
NON-COVERD CHARGES	3,449.00	TOTAL MEDICAID LIAB	3,790.92
		LESS: COB	3,787.92
		LESS: COPAYMENT	3.00
		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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	109.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	726.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,627.00	212.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,546.00	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	150.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,629.00	3,449.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,629.00	3,449.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	47,532.00	ADJUSTMENTS	558.00
COVERED CHARGES	47,171.00	CONTRACTUAL ALLOW	42,891.00
NON-COVERD CHARGES	361.00	TOTAL MEDICAID LIAB	4,280.00
		LESS: COB	21.17
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	4,162.83
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	773.00	20.00	OTHER LAB	698.00	0.00
MED/SURG SUPPLY	187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,132.00	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	12,913.00	341.00
EKG/ECG	107.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,957.00	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	1,844.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	358.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,171.00	361.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,171.00	361.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	95,103.00	ADJUSTMENTS	0.00
COVERED CHARGES	94,302.00	CONTRACTUAL ALLOW	74,476.36
NON-COVERD CHARGES	801.00	TOTAL MEDICAID LIAB	19,825.64
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	19,798.64

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,742.00	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	1,753.00	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	11,807.00	801.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	94,302.00	801.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,302.00	801.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,261.61	ADJUSTMENTS	5,035.59
COVERED CHARGES	119,205.61	CONTRACTUAL ALLOW	35,592.20
NON-COVERD CHARGES	1,056.00	TOTAL MEDICAID LIAB	83,613.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	83,613.41

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	38	0	17,670.00	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	38	0	17,670.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	908.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	908.00	0.00
TOTAL ACCOMODATIONS	39	0	18,578.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,446.27	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,618.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,632.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,748.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,115.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	394.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,561.00	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	2,810.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,798.00	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	4,560.70	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,944.00	1,056.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	100,627.61	1,056.00
TOTAL ACCOMODATIONS	18,578.00	0.00
TOTAL CHARGES	119,205.61	1,056.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	545,716.06	ADJUSTMENTS	24,549.52
COVERED CHARGES	451,814.16	CONTRACTUAL ALLOW	282,695.16
NON-COVERD CHARGES	93,901.90	TOTAL MEDICAID LIAB	169,119.00
		LESS: COB	60.06
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	168,821.94
		ALL OTHER	157,652.79
		FEE SCHEDULE-LAB	9,026.89
		INJECTABLE DRUGS	2,142.26

TOTAL NUMBER OF CLAIMS 470

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,634.84	12,758.90	OTHER LAB	539.00	0.00
MED/SURG SUPPLY	1,807.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,027.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,132.00	7,290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,567.00	48,949.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,902.00	9,661.00
EKG/ECG	8,069.00	486.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,399.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	780.00	564.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,015.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	171,829.00	3,890.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,401.00	3,599.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	293.00
OTHER IMAGING SERVICE	12,094.00	1,906.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	648.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,917.00	2,037.00			

TOTAL ANCILLARY	451,814.16	93,901.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	451,814.16	93,901.90

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 10/01/17 THROUGH 09/30/18
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
407	2218158008321	05/21/18 - 05/21/18	06/11/18	0.00	33.00	0.00	0.00	0.00
405	2218233004488	04/09/18 - 04/09/18	08/27/18	0.00	260.00	0.00	0.00	0.00
TOTAL				0.00	293.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,499.20	ADJUSTMENTS	0.00
COVERED CHARGES	10,146.20	CONTRACTUAL ALLOW	3,348.44
NON-COVERD CHARGES	353.00	TOTAL MEDICAID LIAB	6,797.76
		LESS: COB	6,797.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	327.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	258.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,902.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,019.00	95.00
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	493.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,036.00	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	5.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,146.20	353.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,146.20	353.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	72,386.83	ADJUSTMENTS	1,137.00
COVERED CHARGES	66,733.83	CONTRACTUAL ALLOW	61,403.83
NON-COVERD CHARGES	5,653.00	TOTAL MEDICAID LIAB	5,330.00
		LESS: COB	43.18
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	5,073.82
		TOTAL NUMBER OF CLAIMS	99

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,135.00	1,661.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	143.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	19.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,496.00	286.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,567.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,292.00	1,166.00
EKG/ECG	648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	34,028.00	96.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	424.00	957.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	66,733.83	5,653.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,733.83	5,653.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,135,619.17	ADJUSTMENTS	5,117.81
COVERED CHARGES	1,070,024.30	CONTRACTUAL ALLOW	761,463.54
NON-COVERD CHARGES	65,594.87	TOTAL MEDICAID LIAB	308,560.76
		LESS: COB	1,211.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	307,349.10

TOTAL NUMBER OF ADMISSIONS 40

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	124	0	103,693.00	46,593.18
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	124	0	103,693.00	46,593.18
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	124	0	103,693.00	46,593.18

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,438.39	0.00	OTHER LAB	3,288.48	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	261,282.09	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,713.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,804.28	19,001.69	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	62,949.07	0.00	MRI SERVICES	6,948.07	0.00
IV THERAPY	24,949.15	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	152,840.13	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,724.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	215,176.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.62	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,370.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,123.09	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,623.20	0.00			

TOTAL ANCILLARY	966,331.30	19,001.69
TOTAL ACCOMODATIONS	103,693.00	46,593.18
TOTAL CHARGES	1,070,024.30	65,594.87

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,640,278.96	ADJUSTMENTS	76,020.95
COVERED CHARGES	6,183,339.49	CONTRACTUAL ALLOW	5,468,404.38
NON-COVERD CHARGES	456,939.47	TOTAL MEDICAID LIAB	714,935.11
		LESS: COB	1,040.02
		LESS: COPAYMENT	1,847.28
		REIMBURSEMENT	712,047.81
		ALL OTHER	619,377.57
		FEE SCHEDULE-LAB	83,176.68
		INJECTABLE DRUGS	9,493.56

TOTAL NUMBER OF CLAIMS 2,189

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,138.21	11,153.61	OTHER LAB	10,362.37	0.00
MED/SURG SUPPLY	12,689.06	581.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	307,728.86	7,916.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	682,850.58	56,279.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	298,501.72	7,553.40	FEE SCHEDULE LAB	1,492,649.56	143,836.60
EKG/ECG	181,288.92	8,866.53	MRI SERVICES	90,523.62	3,789.38
IV THERAPY	512,294.83	96,705.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	163,595.69	26,330.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,745.58	6,011.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,785.00	3,405.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,916,980.35	26,551.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,197.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	254,363.68	21,380.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,286.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	15,623.36
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,389.04	10,179.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,462.80	8,487.60			
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	40,744.62	0.00			

TOTAL ANCILLARY	6,183,339.49	456,939.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,183,339.49	456,939.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,256.06	ADJUSTMENTS	0.00
COVERED CHARGES	31,073.62	CONTRACTUAL ALLOW	14,403.47
NON-COVERD CHARGES	4,182.44	TOTAL MEDICAID LIAB	16,670.15
		LESS: COB	16,667.15
		LESS: COPAYMENT	3.00
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	561.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,042.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,560.87	1,744.22
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,822.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	16,218.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,798.40	4.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,111.82	391.66			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,073.62	4,182.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,073.62	4,182.44

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	330,840.29	ADJUSTMENTS	4,518.88
COVERED CHARGES	314,241.25	CONTRACTUAL ALLOW	300,669.77
NON-COVERD CHARGES	16,599.04	TOTAL MEDICAID LIAB	13,571.48
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	13,238.48
		TOTAL NUMBER OF CLAIMS	199

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	145.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,182.90	1,379.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,117.42	4,302.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,242.47	7,305.72
EKG/ECG	2,450.38	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,753.67	620.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	768.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,978.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,645.54	2,022.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	822.48	822.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	314,241.25	16,599.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	314,241.25	16,599.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,206.62	ADJUSTMENTS	0.00
COVERED CHARGES	4,206.62	CONTRACTUAL ALLOW	2,371.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,834.79
		LESS: COB	1,834.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	488.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,303.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,414.12	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,206.62	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,206.62	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

----------CHARGES----------		----------PAYMENTS----------	
TOTAL CHARGES	509,382.88	ADJUSTMENTS	31,997.88
COVERED CHARGES	445,042.64	CONTRACTUAL ALLOW	413,026.76
NON-COVERD CHARGES	64,340.24	TOTAL MEDICAID LIAB	32,015.88
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	31,997.88

TOTAL NUMBER OF CLAIMS 6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
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SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	717.26	116.47	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,657.13	3,463.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,240.80	1,376.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,042.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,889.23	0.00
EKG/ECG	987.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	272.74	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	233,688.34	21,375.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,745.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,349.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,757.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98,101.69	4,679.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,594.10	33,328.48
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	445,042.64	64,340.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	445,042.64	64,340.24

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,960,672.21	ADJUSTMENTS	152,498.63
COVERED CHARGES	13,328,508.21	CONTRACTUAL ALLOW	9,685,322.71
NON-COVERD CHARGES	632,164.00	TOTAL MEDICAID LIAB	3,643,185.50
		LESS: COB	44,625.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,598,559.79

TOTAL NUMBER OF ADMISSIONS 402

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	991	0	658,024.00	525,707.00
ROUTINE NURSERY	109	0	146,648.00	38,292.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,100	0	804,672.00	563,999.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	235	0	798,491.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	235	0	798,491.00	0.00
TOTAL ACCOMODATIONS	1,335	0	1,603,163.00	563,999.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,822,429.08	0.00	OTHER LAB	135,748.00	0.00
MED/SURG SUPPLY	212,427.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,020,255.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	231,064.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,138,854.00	4,180.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	191,849.92	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	144,861.00	0.00	MRI SERVICES	110,036.00	0.00
IV THERAPY	886.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	923,060.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	140,552.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,172,624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,166.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	125,757.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,341,224.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	194,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	19,535.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,835.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,797.26	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	272,115.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,293.00	4,586.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	345,323.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	97,294.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	290,654.00	39,710.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,301.00	19,689.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	351,768.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,682.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,354.75	0.00			

TOTAL ANCILLARY	11,725,345.21	68,165.00
TOTAL ACCOMODATIONS	1,603,163.00	563,999.00
TOTAL CHARGES	13,328,508.21	632,164.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,213.32	ADJUSTMENTS	0.00
COVERED CHARGES	18,699.32	CONTRACTUAL ALLOW	6,078.97
NON-COVERD CHARGES	1,514.00	TOTAL MEDICAID LIAB	12,620.35
		LESS: COB	12,620.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,328.00	1,514.00
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	1,328.00	1,514.00
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	1,328.00	1,514.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,159.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	485.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	382.00	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	7,946.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,266.00	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	3,369.00	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	1,526.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,371.32	0.00
TOTAL ACCOMODATIONS	1,328.00	1,514.00
TOTAL CHARGES	18,699.32	1,514.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,813,426.18	ADJUSTMENTS	533,734.28
COVERED CHARGES	13,579,607.09	CONTRACTUAL ALLOW	10,884,432.55
NON-COVERD CHARGES	2,233,819.09	TOTAL MEDICAID LIAB	2,695,174.54
		LESS: COB	20,179.05
		LESS: COPAYMENT	2,928.00
		REIMBURSEMENT	2,672,067.49
		ALL OTHER	2,516,499.69
		FEE SCHEDULE-LAB	127,100.24
		INJECTABLE DRUGS	28,467.56

TOTAL NUMBER OF CLAIMS 3,518

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,163.27	0.00	OTHER LAB	197,020.00	1,913.00
MED/SURG SUPPLY	143,008.56	11,164.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	661,882.00	141,720.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,605,506.00	528,873.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	74,694.00	47,989.28	FEE SCHEDULE LAB	1,928,206.00	89,430.00
EKG/ECG	232,681.00	7,088.00	MRI SERVICES	331,369.00	55,935.00
IV THERAPY	79,365.00	5,636.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	505,052.00	353,190.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,091.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,929.00	264,530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,835.00	1,738.00	AMBULANCE	0.00	0.00
GI SERVICES	28,347.00	3,066.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,762,164.00	228,042.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	199,046.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,182.69	216,955.09
RADIOLOGY THERAPEUTIC	1,988.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	8,805.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,188.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	57,272.00	8,934.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,438.12	32,215.19
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	534.00
OTHER IMAGING SERVICE	318,344.00	85,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,411.00	4,180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	125,959.00	65,808.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	123,192.00	20,826.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	110,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	321,333.45	25,797.00			

TOTAL ANCILLARY	13,579,607.09	2,233,819.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,579,607.09	2,233,819.09

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 07/01/17 THROUGH 06/30/18
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	2218127006103	07/12/17 - 07/12/17	05/14/18	0.00	534.00	0.00	0.00	0.00
TOTAL				0.00	534.00	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 NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	78,017.34	ADJUSTMENTS	0.00
COVERED CHARGES	49,855.94	CONTRACTUAL ALLOW	29,081.49
NON-COVERD CHARGES	28,161.40	TOTAL MEDICAID LIAB	20,774.45
		LESS: COB	20,762.45
		LESS: COPAYMENT	12.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	881.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,604.00	3,466.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,864.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,732.00	440.00
EKG/ECG	1,329.00	0.00	MRI SERVICES	0.00	7,890.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	760.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	982.00	755.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,519.00	1,135.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,148.38	120.40
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	406.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,727.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	7,668.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,230.00	3,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,331.30	0.00			

TOTAL ANCILLARY	49,855.94	28,161.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,855.94	28,161.40

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	371,360.81	ADJUSTMENTS	158.82
COVERED CHARGES	342,233.53	CONTRACTUAL ALLOW	332,723.73
NON-COVERD CHARGES	29,127.28	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	261.00
		REIMBURSEMENT	9,248.80
		TOTAL NUMBER OF CLAIMS	170

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,637.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	433.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,631.00	8,572.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,804.00	12,771.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,963.00	368.00
EKG/ECG	4,430.00	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	702.00	740.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,895.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204,638.00	1,297.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,334.64	4,217.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,797.00	1,162.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,968.45	0.00			

TOTAL ANCILLARY	342,233.53	29,127.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,233.53	29,127.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,020.85	ADJUSTMENTS	0.00
COVERED CHARGES	4,443.85	CONTRACTUAL ALLOW	2,923.78
NON-COVERD CHARGES	577.00	TOTAL MEDICAID LIAB	1,520.07
		LESS: COB	1,520.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	727.00	537.00	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	532.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,161.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	4,443.85	577.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,443.85	577.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,037,456.97	ADJUSTMENTS	55,416.30
COVERED CHARGES	945,767.79	CONTRACTUAL ALLOW	805,301.97
NON-COVERD CHARGES	91,689.18	TOTAL MEDICAID LIAB	140,465.82
		LESS: COB	6,007.20
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	134,314.62
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,050.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38,945.85	8,876.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,739.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,293.00	7,910.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,520.02	FEE SCHEDULE LAB	16,029.00	1,123.00
EKG/ECG	1,329.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	243,893.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,561.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,978.00	736.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	338,016.68	7,173.07
RADIOLOGY THERAPEUTIC	13,229.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	499.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,788.00	58,894.57
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,188.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,759.20	0.00			

TOTAL ANCILLARY	945,767.79	91,689.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	945,767.79	91,689.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	162,201,574.30	ADJUSTMENTS	9,799,866.88
COVERED CHARGES	154,940,235.61	CONTRACTUAL ALLOW	122,407,283.84
NON-COVERD CHARGES	7,261,338.69	TOTAL MEDICAID LIAB	32,532,951.77
		LESS: COB	294,708.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,238,243.01

TOTAL NUMBER OF ADMISSIONS 5,575

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,527	0	12,931,526.00	1,414,448.00
ROUTINE NURSERY	9,847	0	17,424,341.00	3,780,294.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20,374	0	30,355,867.00	5,194,742.00
SPECIAL CARE SERVICES				
CCU	13	0	57,213.00	0.00
ICU	2,758	0	11,485,324.00	15,996.00
NICU	1,142	0	7,410,287.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,913	0	18,952,824.00	15,996.00
TOTAL ACCOMODATIONS	24,287	0	49,308,691.00	5,210,738.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,121,557.13	168,615.97	OTHER LAB	546,635.00	2,700.00
MED/SURG SUPPLY	3,289,723.64	92,183.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,398,351.82	294,090.22	EDUCATION & TRAINING	13,555.00	929.00
RADIOLOGY-DIAGNOSTIC	1,706,155.50	1,912.00	OTHER THERAPEUTIC SVC	0.00	30,449.00
CT SCAN	2,519,784.00	5,616.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	869,960.00	27,172.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	333,540.00	736.00	MRI SERVICES	958,723.00	11,080.00
IV THERAPY	288,938.00	10,198.00	PROFESSIONAL FEES	0.00	390.00
OPERATING ROOM	6,783,273.00	114,081.00	DURABLE MED. EQUIP.	0.00	3,197.00
LABOR/DELIVERY ROOM	9,773,026.50	9,804.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,949,456.03	16,056.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,275,040.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,872.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,277,938.00	1,479.00	SPECIAL SERVICES	0.00	31,258.00
RECOVERY ROOM	1,880,938.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	67,384.00
LABORATORY PATHOLOGIC	1,656,300.00	0.00	INJECTABLE DRUGS	22,920,103.35	24,381.00
RADIOLOGY THERAPEUTIC	834,835.00	9,487.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	771,769.00	12,821.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	329,056.00	2,709.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	590,636.00	71,348.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	254.00	3,860.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	440.00	0.00	IMPL DEV CHARGE PATIENTS	834,268.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	922,882.00	110,415.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,054,925.00	880,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	245,258.00	33,360.00			
AUDIOLOGY	777,123.00	0.00			
CARDIOLOGY	1,493,065.00	12,826.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	140,902.00	0.00			
ORGAN ACQUISITION	8,463.64	0.00			
TREATMENT/OBSERV. RM	56,797.00	0.00			

TOTAL ANCILLARY	105,631,544.61	2,050,600.69
TOTAL ACCOMODATIONS	49,308,691.00	5,210,738.00
TOTAL CHARGES	154,940,235.61	7,261,338.69

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,019,888.68	ADJUSTMENTS	0.00
COVERED CHARGES	18,162,964.68	CONTRACTUAL ALLOW	8,867,157.29
NON-COVERD CHARGES	856,924.00	TOTAL MEDICAID LIAB	9,295,807.39
		LESS: COB	9,295,807.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 147

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	363	0	448,081.00	49,483.00
ROUTINE NURSERY	1,195	0	4,317,091.00	748,130.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,558	0	4,765,172.00	797,613.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	75	0	293,878.00	0.00
NICU	752	0	4,815,531.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	827	0	5,109,409.00	0.00
TOTAL ACCOMODATIONS	2,385	0	9,874,581.00	797,613.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,577,767.60	0.00	OTHER LAB	117,094.00	0.00
MED/SURG SUPPLY	466,903.00	414.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,222,288.08	0.00	EDUCATION & TRAINING	2,000.00	0.00
RADIOLOGY-DIAGNOSTIC	358,345.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,832.00
CT SCAN	65,398.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	85,362.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,464.00	0.00	MRI SERVICES	24,092.00	0.00
IV THERAPY	1,770.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	404,044.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	319,437.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,302,401.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,673.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,026.00	0.00	SPECIAL SERVICES	0.00	56,065.00
RECOVERY ROOM	71,655.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	21,095.00	0.00	INJECTABLE DRUGS	603,075.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	151,872.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	66,359.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	440.00	0.00	IMPL DEV CHARGE PATIENTS	5,018.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,109.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	125,897.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	39,031.00	0.00			
CARDIOLOGY	128,225.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,543.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,288,383.68	59,311.00
TOTAL ACCOMODATIONS	9,874,581.00	797,613.00
TOTAL CHARGES	18,162,964.68	856,924.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,688,603.57	ADJUSTMENTS	2,462,526.31
COVERED CHARGES	38,087,776.06	CONTRACTUAL ALLOW	30,291,394.56
NON-COVERD CHARGES	3,600,827.51	TOTAL MEDICAID LIAB	7,796,381.50
		LESS: COB	54,278.29
		LESS: COPAYMENT	25,992.40
		REIMBURSEMENT	7,716,110.81
		ALL OTHER	5,434,220.43
		FEE SCHEDULE-LAB	725,535.48
		INJECTABLE DRUGS	1,556,354.90

TOTAL NUMBER OF CLAIMS 10,295

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	482,757.24	6,613.17	OTHER LAB	200,493.00	542.00
MED/SURG SUPPLY	499,535.63	8,111.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	744.00	EDUCATION & TRAINING	3,471.00	620.00
RADIOLOGY-DIAGNOSTIC	569,472.00	5,038.00	OTHER THERAPEUTIC SVC	0.00	7,704.00
CT SCAN	2,996,334.00	499,621.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,927.00	18,465.00	FEE SCHEDULE LAB	11,457,414.21	489,207.20
EKG/ECG	198,972.00	1,840.00	MRI SERVICES	2,534,169.00	143,575.00
IV THERAPY	3,155,920.00	118,385.00	PROFESSIONAL FEES	0.00	2,496.00
OPERATING ROOM	2,593,152.00	339,409.00	DURABLE MED. EQUIP.	0.00	4,227.00
LABOR/DELIVERY ROOM	157,483.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,697.00	5,976.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	668,674.00	931.00	AMBULANCE	0.00	0.00
GI SERVICES	52,326.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,599,281.00	60,046.00	SPECIAL SERVICES	0.00	358.00
RECOVERY ROOM	423,910.00	377.00	DRUG-SPECIFIC/HOME IV	0.00	1,404.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,535,297.90	1,159,749.89
RADIOLOGY THERAPEUTIC	1,529,316.00	6,527.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,626.00	14,312.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,037.00	5,606.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	74,617.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	748,500.00	85,126.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	88,711.00	25,909.00	IMPL DEV CHARGE PATIENTS	191,838.00	6,844.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,747,281.00	322,428.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	903,841.72	13,398.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,450.00	17,789.00			
AUDIOLOGY	3,994.00	0.00			
CARDIOLOGY	121,869.00	70,640.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,460.00	0.00			
ORGAN ACQUISITION	0.00	77,277.00			
TREATMENT/OBSERV. RM	352,566.36	4,915.00			

TOTAL ANCILLARY	38,087,776.06	3,600,827.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,087,776.06	3,600,827.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,462,208.14	ADJUSTMENTS	0.00
COVERED CHARGES	914,107.24	CONTRACTUAL ALLOW	336,925.88
NON-COVERD CHARGES	548,100.90	TOTAL MEDICAID LIAB	577,181.36
		LESS: COB	576,851.36
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 246

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,562.07	0.00	OTHER LAB	8,755.00	0.00
MED/SURG SUPPLY	24,181.00	390.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,771.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,491.00	861.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,760.00	37,942.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,200.00	FEE SCHEDULE LAB	192,695.00	14,380.00
EKG/ECG	4,784.00	368.00	MRI SERVICES	15,828.00	5,276.00
IV THERAPY	49,169.00	3,687.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,314.00	150,209.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,752.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,078.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,021.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,021.00	4,804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,517.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	103,891.17	270,071.90
RADIOLOGY THERAPEUTIC	7,701.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	832.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,897.00	1,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,347.00	0.00	IMPL DEV CHARGE PATIENTS	18,473.00	12,878.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,500.00	41,307.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,943.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	215.00	117.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,212.00	0.00			

TOTAL ANCILLARY	914,107.24	548,100.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	914,107.24	548,100.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	367,578.41	ADJUSTMENTS	2,827.12
COVERED CHARGES	342,336.09	CONTRACTUAL ALLOW	335,298.77
NON-COVERD CHARGES	25,242.32	TOTAL MEDICAID LIAB	7,037.32
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	6,812.32
		TOTAL NUMBER OF CLAIMS	119

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,706.42	0.00	OTHER LAB	2,652.00	0.00
MED/SURG SUPPLY	6,478.00	174.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,146.00	561.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,284.00	6,266.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,836.00	702.00
EKG/ECG	6,274.00	0.00	MRI SERVICES	0.00	5,276.00
IV THERAPY	1,499.00	982.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,411.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,227.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	163,248.00	3,943.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	935.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,126.67	2,489.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,479.00	4,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,034.00	0.00			

TOTAL ANCILLARY	342,336.09	25,242.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	342,336.09	25,242.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,430.50	ADJUSTMENTS	0.00
COVERED CHARGES	29,383.00	CONTRACTUAL ALLOW	19,685.81
NON-COVERD CHARGES	12,047.50	TOTAL MEDICAID LIAB	9,697.19
		LESS: COB	9,697.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY RD NE
ATLANTA,GA 30342-1606

PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,227.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.00	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	5,663.00	0.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	8,198.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,243.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,200.00	1,588.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,051.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,969.50	1,319.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,258.00	942.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	29,383.00	12,047.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,383.00	12,047.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,609,744.35	ADJUSTMENTS	705,902.46
COVERED CHARGES	8,219,691.92	CONTRACTUAL ALLOW	6,228,607.76
NON-COVERD CHARGES	390,052.43	TOTAL MEDICAID LIAB	1,991,084.16
		LESS: COB	2,729.45
		LESS: COPAYMENT	2,463.00
		REIMBURSEMENT	1,985,891.71

TOTAL NUMBER OF CLAIMS 360

GEORGIA 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
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PROVIDER NUMBER
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,164.56	2,438.00	OTHER LAB	3,320.00	0.00
MED/SURG SUPPLY	268,263.98	1,065.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,669.00	37,771.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,786.00	19,965.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,470.00	FEE SCHEDULE LAB	686,991.00	55,008.00
EKG/ECG	10,394.00	482.00	MRI SERVICES	14,843.00	0.00
IV THERAPY	793,470.00	12,548.00	PROFESSIONAL FEES	0.00	390.00
OPERATING ROOM	866,307.00	66,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,810.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	134,691.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,436.00	530.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,348,341.78	111,806.43
RADIOLOGY THERAPEUTIC	639,386.00	9,767.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,372.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,047.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,609.00	12,384.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	645,347.00	17,034.00
LITHOTRIPSY	93,408.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,866.00	707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,349.00	1,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,082.00	1,964.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	86,093.00	22,689.00			
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	40,476.60	8,087.00			

TOTAL ANCILLARY	8,219,691.92	390,052.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,219,691.92	390,052.43

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	803,133.55	ADJUSTMENTS	0.00
COVERED CHARGES	700,770.85	CONTRACTUAL ALLOW	349,502.65
NON-COVERD CHARGES	102,362.70	TOTAL MEDICAID LIAB	351,268.20
		LESS: COB	351,151.20
		LESS: COPAYMENT	117.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,169.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,369.00	95.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	822.00	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	3,508.00	FEE SCHEDULE LAB	37,478.00	1,934.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,186.00	390.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,023.00	64,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,021.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,023.00	931.00	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	11,748.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	358,376.95	16,829.70
RADIOLOGY THERAPEUTIC	59,948.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,622.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	965.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,257.00	12,959.00
LITHOTRIPSY	23,352.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,664.00	0.00			

TOTAL ANCILLARY	700,770.85	102,362.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	700,770.85	102,362.70

** 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,177,456.63	ADJUSTMENTS	9,410.84
COVERED CHARGES	3,897,304.35	CONTRACTUAL ALLOW	2,842,483.30
NON-COVERD CHARGES	280,152.28	TOTAL MEDICAID LIAB	1,054,821.05
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,054,821.05

TOTAL NUMBER OF ADMISSIONS 126

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	972	0	637,412.00	259,836.00
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	972	0	637,412.00	259,836.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	12,915.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	12,915.00	0.00
TOTAL ACCOMODATIONS	979	0	650,327.00	259,836.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	928,429.14	0.00	OTHER LAB	35,373.00	0.00
MED/SURG SUPPLY	225,607.79	252.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	382,982.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,074.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	233,182.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	224,296.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,488.00	0.00	MRI SERVICES	73,369.00	0.00
IV THERAPY	21,853.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	148,749.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,997.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,672.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	213,373.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,230.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,329.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	238,236.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	70,506.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	112.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,206.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,049.00
OTHER IMAGING SERVICE	23,295.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,551.00	16,753.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	22,264.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,013.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,838.00	150.00			

TOTAL ANCILLARY	3,246,977.35	20,316.28
TOTAL ACCOMODATIONS	650,327.00	259,836.00
TOTAL CHARGES	3,897,304.35	280,152.28

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 08/01/17 THROUGH 07/31/18
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	2019007031088	03/14/18 - 03/16/18	01/14/19	0.00	3,049.00	0.00	0.00	0.00
TOTAL				0.00	3,049.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,881,386.78	ADJUSTMENTS	49,812.98
COVERED CHARGES	1,688,717.39	CONTRACTUAL ALLOW	1,315,470.52
NON-COVERD CHARGES	192,669.39	TOTAL MEDICAID LIAB	373,246.87
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	372,829.87
		ALL OTHER	355,943.93
		FEE SCHEDULE-LAB	14,144.58
		INJECTABLE DRUGS	2,741.36

TOTAL NUMBER OF CLAIMS 376

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,805.23	141.00	OTHER LAB	1,278.00	0.00
MED/SURG SUPPLY	66,058.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,187.00	666.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	493,450.00	75,605.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,937.00	4,791.00
EKG/ECG	8,729.00	0.00	MRI SERVICES	4,947.00	2,583.00
IV THERAPY	14,709.00	2,832.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	401,747.00	76,846.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,248.00	3,511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,928.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291,340.00	8,752.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,845.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97,614.45	10,152.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,049.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,786.00	5,522.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,034.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,865.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,539.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,763.00	1,166.00			

TOTAL ANCILLARY	1,688,717.39	192,669.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,688,717.39	192,669.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,209.94	ADJUSTMENTS	0.00
COVERED CHARGES	11,653.94	CONTRACTUAL ALLOW	3,930.05
NON-COVERD CHARGES	1,556.00	TOTAL MEDICAID LIAB	7,723.89
		LESS: COB	7,717.89
		LESS: COPAYMENT	6.00
		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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 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	195.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,757.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	316.00	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	1,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,149.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	630.00	1,556.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,653.94	1,556.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,653.94	1,556.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,577.32	ADJUSTMENTS	55.94
COVERED CHARGES	22,995.32	CONTRACTUAL ALLOW	22,379.98
NON-COVERD CHARGES	12,582.00	TOTAL MEDICAID LIAB	615.34
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	594.34
		TOTAL NUMBER OF CLAIMS	11

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	631.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,427.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	12,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,613.00	145.00
EKG/ECG	406.00	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	132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,127.00	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	1,641.00	67.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,126.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	586.00	0.00			

TOTAL ANCILLARY	22,995.32	12,582.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,995.32	12,582.00

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 NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	731,602.45	ADJUSTMENTS	11,435.36
COVERED CHARGES	727,614.65	CONTRACTUAL ALLOW	596,004.51
NON-COVERD CHARGES	3,987.80	TOTAL MEDICAID LIAB	131,610.14
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	131,541.14
		TOTAL NUMBER OF CLAIMS	23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,540.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,123.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,300.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,830.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,225.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	589.00	1,575.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	497,673.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,544.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,014.00	225.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,401.30	2,187.80
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	100,146.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,387.00	0.00			

TOTAL ANCILLARY	727,614.65	3,987.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	727,614.65	3,987.80

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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	240,149.42	ADJUSTMENTS	0.00
COVERED CHARGES	236,267.42	CONTRACTUAL ALLOW	113,929.97
NON-COVERD CHARGES	3,882.00	TOTAL MEDICAID LIAB	122,337.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	122,337.45

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	40,150.00	1,288.00
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	72	0	40,150.00	1,288.00
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	72	0	40,150.00	1,288.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,217.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,746.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,472.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,423.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,065.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,225.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,750.00	0.00	PROFESSIONAL FEES	0.00	2,594.00
OPERATING ROOM	2,207.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,618.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	661.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,367.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	349.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,316.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	216.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	373.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,364.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,550.00	0.00			

TOTAL ANCILLARY	196,117.42	2,594.00
TOTAL ACCOMODATIONS	40,150.00	1,288.00
TOTAL CHARGES	236,267.42	3,882.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	992,465.77	ADJUSTMENTS	13,645.25
COVERED CHARGES	942,069.35	CONTRACTUAL ALLOW	680,918.52
NON-COVERD CHARGES	50,396.42	TOTAL MEDICAID LIAB	261,150.83
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	260,895.83
		ALL OTHER	228,657.77
		FEE SCHEDULE-LAB	25,922.37
		INJECTABLE DRUGS	6,315.69

TOTAL NUMBER OF CLAIMS 759

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,756.68	68.00	OTHER LAB	3,056.00	994.00
MED/SURG SUPPLY	36,377.00	189.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,570.00	6,347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	126,294.00	2,969.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,038.00	0.00	FEE SCHEDULE LAB	248,282.00	16,252.00
EKG/ECG	32,459.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,923.00	153.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,129.00	1,533.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,912.00	3,459.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,114.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,527.00	10,284.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,869.67	90.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,734.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	272.00	253.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,298.00	0.00	IMPL DEV CHARGE PATIENTS	584.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,520.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,942.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,332.00	7,805.00			

TOTAL ANCILLARY	942,069.35	50,396.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	942,069.35	50,396.42

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,349.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,197.00	CONTRACTUAL ALLOW	764.44
NON-COVERD CHARGES	152.00	TOTAL MEDICAID LIAB	1,432.56
		LESS: COB	1,432.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.00	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	932.00	152.00
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	1,224.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,197.00	152.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,197.00	152.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,865.84	ADJUSTMENTS	0.00
COVERED CHARGES	17,261.84	CONTRACTUAL ALLOW	16,175.84
NON-COVERD CHARGES	604.00	TOTAL MEDICAID LIAB	1,086.00
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	1,074.00
		TOTAL NUMBER OF CLAIMS	23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	611.84	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	795.00	188.00	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	2,958.00	416.00
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	12,690.00	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	207.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,261.84	604.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,261.84	604.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,105,254.33	ADJUSTMENTS	139,454.85
COVERED CHARGES	17,038,800.56	CONTRACTUAL ALLOW	13,611,906.78
NON-COVERD CHARGES	66,453.77	TOTAL MEDICAID LIAB	3,426,893.78
		LESS: COB	3,359.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,423,534.42

TOTAL NUMBER OF ADMISSIONS 414

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,033	0	1,334,636.00	57,983.00
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	1,033	0	1,334,636.00	57,983.00
SPECIAL CARE SERVICES				
CCU	541	0	1,360,074.00	0.00
ICU	194	0	696,654.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	735	0	2,056,728.00	0.00
TOTAL ACCOMODATIONS	1,768	0	3,391,364.00	57,983.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,610,554.10	0.00	OTHER LAB	124,848.00	0.00
MED/SURG SUPPLY	495,778.26	1,254.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,517,397.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	387,258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,631,586.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,487.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	244,759.00	0.00	MRI SERVICES	311,241.00	0.00
IV THERAPY	403,152.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	628,566.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,577,948.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	334,026.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,554.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,138,337.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,009.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	82,015.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	51,040.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,162.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,860.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	197,604.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,664.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	10,805.00	0.00	IMPL DEV CHARGE PATIENTS	115,485.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	785.00
OTHER IMAGING SERVICE	120,388.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,821.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	218,408.00	443.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	830,157.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,768.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	212,758.46	0.00			

TOTAL ANCILLARY	13,647,436.56	8,470.77
TOTAL ACCOMODATIONS	3,391,364.00	57,983.00
TOTAL CHARGES	17,038,800.56	66,453.77

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 07/01/17 THROUGH 06/30/18
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	2018022012609	01/06/18 - 01/07/18	01/29/18	0.00	157.00	0.00	0.00	0.00
780	2018068049439	01/23/18 - 01/28/18	03/12/18	0.00	157.00	0.00	0.00	0.00
780	2018110050036	04/09/18 - 04/12/18	04/23/18	0.00	157.00	0.00	0.00	0.00
780	2018151063802	05/12/18 - 05/13/18	06/04/18	0.00	157.00	0.00	0.00	0.00
780	2018156046258	05/15/18 - 05/15/18	06/11/18	0.00	157.00	0.00	0.00	0.00
TOTAL				0.00	785.00	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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	61,244.27	ADJUSTMENTS	0.00
COVERED CHARGES	60,572.27	CONTRACTUAL ALLOW	7,240.64
NON-COVERD CHARGES	672.00	TOTAL MEDICAID LIAB	53,331.63
		LESS: COB	53,331.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12	0	15,504.00	672.00
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	15,504.00	672.00
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	15,504.00	672.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,208.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,028.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,302.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,090.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,385.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,447.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	512.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,224.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,616.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,456.50	0.00			

TOTAL ANCILLARY	45,068.27	0.00
TOTAL ACCOMODATIONS	15,504.00	672.00
TOTAL CHARGES	60,572.27	672.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,320,236.97	ADJUSTMENTS	316,050.82
COVERED CHARGES	13,318,974.85	CONTRACTUAL ALLOW	11,786,150.17
NON-COVERD CHARGES	1,001,262.12	TOTAL MEDICAID LIAB	1,532,824.68
		LESS: COB	31,682.37
		LESS: COPAYMENT	2,302.73
		REIMBURSEMENT	1,498,839.58
		ALL OTHER	1,378,497.28
		FEE SCHEDULE-LAB	89,392.98
		INJECTABLE DRUGS	30,949.32

TOTAL NUMBER OF CLAIMS 2,892

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	411,165.43	330.00	OTHER LAB	168,462.00	1,990.00
MED/SURG SUPPLY	139,806.37	4,509.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	802,292.00	7,173.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,653,967.00	236,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,637.00	10,851.15	FEE SCHEDULE LAB	1,756,656.00	81,573.00
EKG/ECG	240,170.00	1,536.00	MRI SERVICES	530,097.00	50,473.00
IV THERAPY	776,690.00	44,948.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	461,830.75	85,131.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,768.00	61,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	261,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,863.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,304,120.00	10,096.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144,828.75	95,501.75
RADIOLOGY THERAPEUTIC	313,511.00	907.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,639.00	1,714.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	29,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,601.00	4,515.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,439.00	45,579.00	IMPL DEV CHARGE PATIENTS	28,833.45	2,205.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	462.00	400.00
OTHER IMAGING SERVICE	307,761.00	64,117.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	188,894.00	25,404.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	234,606.00	128,031.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	137,938.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	180,316.10	6,686.00			

TOTAL ANCILLARY	13,318,974.85	1,001,262.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,318,974.85	1,001,262.12

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 07/01/17 THROUGH 06/30/18
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	5918032001218	12/20/17 - 12/20/17	02/05/18	77.00	0.00	0.00	0.00	20.52
780	5918032001218	12/20/17 - 12/20/17	02/05/18	0.00	80.00	0.00	0.00	0.00
780	2018088060035	03/11/18 - 03/11/18	04/02/18	77.00	0.00	0.00	0.00	20.52
780	2018088060035	03/11/18 - 03/11/18	04/02/18	0.00	80.00	0.00	0.00	0.00
780	5918130000704	04/09/18 - 04/09/18	05/14/18	77.00	0.00	0.00	0.00	20.52
780	5918130000704	04/09/18 - 04/09/18	05/14/18	0.00	80.00	0.00	0.00	0.00
780	2018148005348	05/12/18 - 05/12/18	06/04/18	77.00	0.00	0.00	0.00	20.52
780	5918173000613	03/19/18 - 03/19/18	06/25/18	77.00	0.00	0.00	0.00	20.52
780	5918173000613	03/19/18 - 03/19/18	06/25/18	0.00	80.00	0.00	0.00	0.00
780	2018226060911	04/25/18 - 04/25/18	08/20/18	77.00	0.00	0.00	0.00	20.52
780	2018226060911	04/25/18 - 04/25/18	08/20/18	0.00	80.00	0.00	0.00	0.00
TOTAL				462.00	400.00	0.00	0.00	123.12

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	462,499.13	ADJUSTMENTS	0.00
COVERED CHARGES	393,826.13	CONTRACTUAL ALLOW	249,106.43
NON-COVERD CHARGES	68,673.00	TOTAL MEDICAID LIAB	144,719.70
		LESS: COB	144,695.93
		LESS: COPAYMENT	23.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,147.25	1,426.25	OTHER LAB	7,228.00	0.00
MED/SURG SUPPLY	5,650.30	177.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,088.00	1,057.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,475.00	22,424.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66,892.00	4,021.00
EKG/ECG	7,168.00	0.00	MRI SERVICES	4,678.00	9,228.00
IV THERAPY	43,114.00	888.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,686.00	7,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,536.00	2,673.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,805.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	118,635.00	2,520.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,418.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,560.00	864.75
RADIOLOGY THERAPEUTIC	232.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	3,620.00	IMPL DEV CHARGE PATIENTS	176.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	77.00	200.00
OTHER IMAGING SERVICE	17,035.00	9,349.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,642.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,737.10	474.00			

TOTAL ANCILLARY	393,826.13	68,673.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	393,826.13	68,673.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL
2518 JIMMY LEE SMITH PKWY
HIRAM,GA 30141-2068

PROVIDER NUMBER
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2018214057445	06/23/18 - 06/23/18	08/06/18	77.00	0.00	0.00	1,839.60	0.00
780	2018214057445	06/23/18 - 06/23/18	08/06/18	0.00	80.00	0.00	1,839.60	0.00
948	2018242054512	03/28/18 - 03/28/18	09/03/18	0.00	120.00	0.00	0.00	0.00
TOTAL				77.00	200.00	0.00	3,679.20	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	605,062.25	ADJUSTMENTS	376.58
COVERED CHARGES	560,403.50	CONTRACTUAL ALLOW	545,807.73
NON-COVERD CHARGES	44,658.75	TOTAL MEDICAID LIAB	14,595.77
		LESS: COB	2,344.91
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	11,974.86
		TOTAL NUMBER OF CLAIMS	219

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,429.50	0.00	OTHER LAB	8,128.00	0.00
MED/SURG SUPPLY	1,038.00	359.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,083.00	3,788.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,506.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,778.00	10,456.00
EKG/ECG	7,680.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,192.00	675.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,564.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	283,215.00	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	13,491.75
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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,238.00	11,638.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,552.00	4,140.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	560,403.50	44,658.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	560,403.50	44,658.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,244.00	ADJUSTMENTS	0.00
COVERED CHARGES	40,574.00	CONTRACTUAL ALLOW	35,005.09
NON-COVERD CHARGES	1,670.00	TOTAL MEDICAID LIAB	5,568.91
		LESS: COB	5,553.91
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261.00	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	1,826.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,653.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,120.00	558.00
EKG/ECG	1,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	948.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,883.00	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	1,112.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	859.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,574.00	1,670.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,574.00	1,670.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,169,038.83	ADJUSTMENTS	43,586.40
COVERED CHARGES	1,026,708.71	CONTRACTUAL ALLOW	939,343.91
NON-COVERD CHARGES	142,330.12	TOTAL MEDICAID LIAB	87,364.80
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	87,145.80
		TOTAL NUMBER OF CLAIMS	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,414.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,474.96	47.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	445.00	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	1,071.00	FEE SCHEDULE LAB	2,327.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,962.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,265.00	3,413.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,569.00	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	8,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	552,367.50	115,047.00
RADIOLOGY THERAPEUTIC	350,482.00	11,360.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	18,837.00	11,391.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	1,026,708.71	142,330.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,026,708.71	142,330.12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	660,442.52	ADJUSTMENTS	22,656.77
COVERED CHARGES	659,801.52	CONTRACTUAL ALLOW	334,924.68
NON-COVERD CHARGES	641.00	TOTAL MEDICAID LIAB	324,876.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	324,876.84

TOTAL NUMBER OF ADMISSIONS 60

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	225	0	156,375.00	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	225	0	156,375.00	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	225	0	156,375.00	0.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,846.93	0.00	OTHER LAB	3,746.00	0.00
MED/SURG SUPPLY	32,727.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,245.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,838.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,482.00	641.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	843.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,882.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,285.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,564.00	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	59,410.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	738.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,373.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,412.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,722.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,931.00	0.00			

TOTAL ANCILLARY	503,426.52	641.00
TOTAL ACCOMODATIONS	156,375.00	0.00
TOTAL CHARGES	659,801.52	641.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,509.89	ADJUSTMENTS	0.00
COVERED CHARGES	10,509.89	CONTRACTUAL ALLOW	4,212.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,297.52
		LESS: COB	6,297.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5	0	3,475.00	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	3,475.00	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	0	3,475.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,304.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	656.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,172.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	189.00	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	111.00	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	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	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	515.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,287.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	7,034.89	0.00
TOTAL ACCOMODATIONS	3,475.00	0.00
TOTAL CHARGES	10,509.89	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,348,310.89	ADJUSTMENTS	95,630.62
COVERED CHARGES	2,175,156.61	CONTRACTUAL ALLOW	1,653,078.75
NON-COVERD CHARGES	173,154.28	TOTAL MEDICAID LIAB	522,077.86
		LESS: COB	2,819.09
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	518,181.77
		ALL OTHER	445,745.30
		FEE SCHEDULE-LAB	69,437.20
		INJECTABLE DRUGS	2,999.27

TOTAL NUMBER OF CLAIMS 1,738

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,394.84	427.14	OTHER LAB	143,793.00	0.00
MED/SURG SUPPLY	14,563.71	1,384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	103,191.00	5,851.00	OTHER THERAPEUTIC SVC	0.00	588.00
CT SCAN	290,570.00	54,645.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,082.00	268.00	FEE SCHEDULE LAB	558,633.30	17,614.00
EKG/ECG	26,196.00	555.00	MRI SERVICES	1,656.00	0.00
IV THERAPY	130,829.00	25,834.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,738.34	40,812.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,326.00	6,141.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	444,776.50	3,189.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,114.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,108.92	7,323.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	380.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	392.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	208.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,226.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,599.00	5,223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,111.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,118.00	251.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,287.00	1,287.00			
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	51,145.00	142.00			

TOTAL ANCILLARY	2,175,156.61	173,154.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,175,156.61	173,154.28

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,145.19	ADJUSTMENTS	0.00
COVERED CHARGES	17,995.81	CONTRACTUAL ALLOW	6,472.42
NON-COVERD CHARGES	3,149.38	TOTAL MEDICAID LIAB	11,523.39
		LESS: COB	11,521.90
		LESS: COPAYMENT	1.49
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303.59	0.00	OTHER LAB	3,762.00	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	232.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,514.00	2,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,081.00	0.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	764.00	124.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,612.00	22.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	480.22	273.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	17,995.81	3,149.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,995.81	3,149.38

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	144,762.24	ADJUSTMENTS	3,506.00
COVERED CHARGES	136,447.44	CONTRACTUAL ALLOW	126,087.44
NON-COVERD CHARGES	8,314.80	TOTAL MEDICAID LIAB	10,360.00
		LESS: COB	0.00
		LESS: COPAYMENT	405.00
		REIMBURSEMENT	9,955.00
		TOTAL NUMBER OF CLAIMS	186

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,541.00	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	4,922.00	1,041.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,213.00	5,741.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,032.00	395.00
EKG/ECG	1,110.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,952.00	248.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	746.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,662.00	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	1,879.44	143.80
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	136,447.44	8,314.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,447.44	8,314.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,290.79	ADJUSTMENTS	0.00
COVERED CHARGES	2,290.79	CONTRACTUAL ALLOW	1,842.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	447.96
		LESS: COB	447.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330.23	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	415.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	231.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	954.00	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	360.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,290.79	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,290.79	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,359.09	ADJUSTMENTS	0.00
COVERED CHARGES	23,768.37	CONTRACTUAL ALLOW	18,905.48
NON-COVERD CHARGES	590.72	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,256.00	146.00	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	51.00	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	19,908.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	866.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	427.94	444.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	23,768.37	590.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,768.37	590.72

GEORGIA DEPARTMENT OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,251,522.84	ADJUSTMENTS	124,085.90
COVERED CHARGES	1,203,944.84	CONTRACTUAL ALLOW	644,891.26
NON-COVERD CHARGES	47,578.00	TOTAL MEDICAID LIAB	559,053.58
		LESS: COB	6,110.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	552,943.16

TOTAL NUMBER OF ADMISSIONS 69

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	277	0	282,815.00	44,045.00
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	277	0	282,815.00	44,045.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	41	0	102,500.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	102,500.00	0.00
TOTAL ACCOMODATIONS	318	0	385,315.00	44,045.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,000.17	0.00	OTHER LAB	3,748.00	0.00
MED/SURG SUPPLY	10,170.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	97,836.22	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,968.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,500.00	1,533.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,080.78	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,714.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,572.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123,319.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,050.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,966.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,552.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,497.76	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	3,377.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	526.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,906.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,000.00
OTHER IMAGING SERVICE	4,245.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,067.97	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,267.63	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,262.50	0.00			

TOTAL ANCILLARY	818,629.84	3,533.00
TOTAL ACCOMODATIONS	385,315.00	44,045.00
TOTAL CHARGES	1,203,944.84	47,578.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2018333069023	11/14/18 - 11/21/18	12/03/18	0.00	1,000.00	0.00	0.00	0.00
618	2319064000133	09/19/18 - 09/24/18	03/25/19	0.00	1,000.00	0.00	719.65	0.00
TOTAL				0.00	2,000.00	0.00	719.65	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,504,020.99	ADJUSTMENTS	66,566.96
COVERED CHARGES	2,432,490.27	CONTRACTUAL ALLOW	2,008,538.57
NON-COVERD CHARGES	71,530.72	TOTAL MEDICAID LIAB	423,951.70
		LESS: COB	647.12
		LESS: COPAYMENT	999.36
		REIMBURSEMENT	422,305.22
		ALL OTHER	357,006.77
		FEE SCHEDULE-LAB	47,195.40
		INJECTABLE DRUGS	18,103.05

TOTAL NUMBER OF CLAIMS 1,188

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,342.43	476.16	OTHER LAB	102,396.00	0.00
MED/SURG SUPPLY	11,200.80	12.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,794.56	522.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,250.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	168,722.97	15,387.33
EKG/ECG	57,169.00	0.00	MRI SERVICES	15,000.00	0.00
IV THERAPY	30,904.50	5,943.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	193,604.35	20,425.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,360.50	3,055.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,419,664.14	3,174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,770.17	10,166.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	508.02	254.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,302.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,301.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,545.82	4,044.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	515.09	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,818.64	2,266.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,165.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,824.50	0.00			

TOTAL ANCILLARY	2,432,490.27	71,530.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,432,490.27	71,530.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,759.97	ADJUSTMENTS	0.00
COVERED CHARGES	32,055.31	CONTRACTUAL ALLOW	17,102.01
NON-COVERD CHARGES	4,704.66	TOTAL MEDICAID LIAB	14,953.30
		LESS: COB	14,942.27
		LESS: COPAYMENT	11.03
		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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	88.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,710.28	870.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	2,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,000.70	241.56
EKG/ECG	1,192.00	0.00	MRI SERVICES	0.00	1,000.00
IV THERAPY	444.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,562.50	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	3,869.01	9.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,233.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,055.31	4,704.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,055.31	4,704.66

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	45,798.65	ADJUSTMENTS	639.92
COVERED CHARGES	45,542.99	CONTRACTUAL ALLOW	44,077.34
NON-COVERD CHARGES	255.66	TOTAL MEDICAID LIAB	1,465.65
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	1,432.65
		TOTAL NUMBER OF CLAIMS	24

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.20	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	1,203.34	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	1,698.45	237.36
EKG/ECG	1,192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,166.00	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	102.00	18.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	45,542.99	255.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,542.99	255.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,020.38	ADJUSTMENTS	0.00
COVERED CHARGES	11,582.02	CONTRACTUAL ALLOW	7,191.02
NON-COVERD CHARGES	2,438.36	TOTAL MEDICAID LIAB	4,391.00
		LESS: COB	4,382.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	332.84	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	348.20	348.20	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	350.13	55.41
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,302.00	1,700.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	320.01	1.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	332.84	332.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	11,582.02	2,438.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,582.02	2,438.36

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

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.
417 W 3RD AVE
ALBANY,GA 31701-1943

PROVIDER NUMBER
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	71,037,540.18	ADJUSTMENTS	2,013,441.04
COVERED CHARGES	69,031,873.80	CONTRACTUAL ALLOW	48,027,857.32
NON-COVERD CHARGES	2,005,666.38	TOTAL MEDICAID LIAB	21,004,016.48
		LESS: COB	227,612.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,776,404.34

TOTAL NUMBER OF ADMISSIONS 1,888

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9,196	0	6,030,861.00	1,056,921.00
ROUTINE NURSERY	636	0	419,158.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	16,510.38
TOTAL ROUTINE	9,832	0	6,450,019.00	1,073,431.38
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,160	0	2,168,570.00	0.00
NICU	669	0	1,374,328.00	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	1,829	0	3,542,898.00	0.00
TOTAL ACCOMODATIONS	11,661	0	9,992,917.00	1,073,431.38

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,229,817.12	1,558.93	OTHER LAB	414,708.00	0.00
MED/SURG SUPPLY	6,404,498.34	105,470.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,507,226.88	16,897.70	EDUCATION & TRAINING	77.00	0.00
RADIOLOGY-DIAGNOSTIC	1,330,411.00	0.00	OTHER THERAPEUTIC SVC	0.00	42,186.00
CT SCAN	2,536,230.00	51,878.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	676,301.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	358,508.00	0.00	MRI SERVICES	637,457.00	0.00
IV THERAPY	335,105.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,659,181.00	93,899.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	272,236.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,149,937.00	2,400.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,508,566.50	396.00	AMBULANCE	0.00	0.00
GI SERVICES	201,240.00	5,418.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,420,003.00	472.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,188,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	225,838.00	0.00	INJECTABLE DRUGS	1,663.00	0.00
RADIOLOGY THERAPEUTIC	474,140.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	409,807.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	145,446.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60.00	13,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	260,124.00	0.00	IMPL DEV CHARGE PATIENTS	3,747,376.96	3,527.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	34,105.06
OTHER IMAGING SERVICE	378,790.00	5,426.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	514,630.00	538,365.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	168,613.00	0.00			
AUDIOLOGY	73,577.00	0.00			
CARDIOLOGY	2,484,779.00	3,100.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,338.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,277,672.00	14,129.00			

TOTAL ANCILLARY	59,038,956.80	932,235.00
TOTAL ACCOMODATIONS	9,992,917.00	1,073,431.38
TOTAL CHARGES	69,031,873.80	2,005,666.38

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 08/01/17 THROUGH 07/31/18
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	2017272073266	09/16/17 - 09/19/17	10/09/17	0.00	3,049.00	0.00	0.00	0.00
615	2017303032119	10/09/17 - 10/24/17	11/06/17	0.00	3,049.00	0.00	0.00	0.00
615	2017338041708	11/24/17 - 11/27/17	12/11/17	0.00	3,049.00	0.00	0.00	0.00
615	2017338041724	11/23/17 - 11/29/17	12/11/17	0.00	3,049.00	0.00	0.00	0.00
615	2118040000007	10/21/17 - 10/26/17	02/26/18	0.00	3,049.00	0.00	2,087.12	0.00
615	2018064035719	01/17/18 - 02/10/18	03/12/18	0.00	3,049.00	0.00	0.00	0.00
615	2018107074531	04/05/18 - 04/06/18	04/23/18	0.00	3,049.00	0.00	0.00	0.00
615	2018309043720	03/07/18 - 03/11/18	11/12/18	0.00	3,049.00	0.00	0.00	0.00
615	2218324001835	02/25/18 - 04/03/18	11/26/18	0.00	3,049.00	0.00	0.00	0.00
284	2218331006887	06/27/18 - 06/30/18	12/03/18	0.00	566.06	0.00	0.00	0.00
615	2019075001632	12/15/17 - 12/28/17	03/25/19	0.00	3,049.00	0.00	0.00	0.00
615	2019225090240	11/26/17 - 12/11/17	08/19/19	0.00	3,049.00	0.00	0.00	0.00
TOTAL				0.00	34,105.06	0.00	2,087.12	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	136,616.79	ADJUSTMENTS	0.00
COVERED CHARGES	134,085.79	CONTRACTUAL ALLOW	41,359.07
NON-COVERD CHARGES	2,531.00	TOTAL MEDICAID LIAB	92,726.72
		LESS: COB	92,726.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	49	0	32,127.00	1,423.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	49	0	32,127.00	1,423.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	49	0	32,127.00	1,423.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,180.61	0.00	OTHER LAB	3,265.00	0.00
MED/SURG SUPPLY	10,396.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,998.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,305.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	406.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,511.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,825.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,302.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,095.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,895.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,023.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	750.00	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	714.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	339.00	1,108.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,144.00	0.00			

TOTAL ANCILLARY	101,958.79	1,108.00
TOTAL ACCOMODATIONS	32,127.00	1,423.00
TOTAL CHARGES	134,085.79	2,531.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	36,824,580.75	ADJUSTMENTS	1,398,111.06
COVERED CHARGES	32,793,988.78	CONTRACTUAL ALLOW	25,421,106.08
NON-COVERD CHARGES	4,030,591.97	TOTAL MEDICAID LIAB	7,372,882.70
		LESS: COB	8,557.22
		LESS: COPAYMENT	25,827.61
		REIMBURSEMENT	7,338,497.87
		ALL OTHER	5,684,256.70
		FEE SCHEDULE-LAB	601,608.63
		INJECTABLE DRUGS	1,052,632.54

TOTAL NUMBER OF CLAIMS 14,120

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,028,284.64	5,912.65	OTHER LAB	232,410.00	1,490.00
MED/SURG SUPPLY	1,690,027.65	698.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	496.00	EDUCATION & TRAINING	0.00	154.00
RADIOLOGY-DIAGNOSTIC	967,956.00	50,729.00	OTHER THERAPEUTIC SVC	0.00	1,488.00
CT SCAN	2,310,219.00	401,935.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,515.00	29,429.43	FEE SCHEDULE LAB	2,706,209.08	599,719.00
EKG/ECG	263,163.00	12,789.00	MRI SERVICES	792,589.00	60,809.00
IV THERAPY	1,042,479.00	102,039.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,449,486.73	359,133.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,632.00	0.00	REHAB THERAPY	0.00	1,940.00
RESPIRATORY SERVICES	173,543.00	45,884.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	904,248.00	6,048.00	AMBULANCE	0.00	0.00
GI SERVICES	680,399.55	223,778.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,448,800.00	147,940.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,349,709.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,832,671.84	1,035,760.06
RADIOLOGY THERAPEUTIC	1,555,263.00	329,954.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,401.00	3,065.17	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	35,594.00	22,038.82	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	263,466.00	43,467.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	34,821.00	114,389.00	IMPL DEV CHARGE PATIENTS	405,203.36	218.89
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,199.00
OTHER IMAGING SERVICE	808,337.00	57,974.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,541.00	93,625.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	603,258.00	40,728.00			
AUDIOLOGY	457.00	0.00			
CARDIOLOGY	642,478.50	112,649.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	477,904.00	3,891.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	811,922.43	115,221.00			

TOTAL ANCILLARY	32,793,988.78	4,030,591.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,793,988.78	4,030,591.97

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 08/01/17 THROUGH 07/31/18
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	2017269069521	09/19/17 - 09/19/17	10/02/17	0.00	2,608.00	0.00	0.00	0.00
9300	5918064000928	02/11/18 - 02/11/18	03/12/18	0.00	203.00	0.00	0.00	0.00
615	2018073000015	03/07/18 - 03/07/18	03/19/18	0.00	2,388.00	0.00	0.00	0.00
TOTAL				0.00	5,199.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	499,896.48	ADJUSTMENTS	0.00
COVERED CHARGES	307,760.90	CONTRACTUAL ALLOW	35,108.22
NON-COVERD CHARGES	192,135.58	TOTAL MEDICAID LIAB	272,652.68
		LESS: COB	272,326.54
		LESS: COPAYMENT	326.14
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 236

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,859.32	8.00	OTHER LAB	1,113.00	0.00
MED/SURG SUPPLY	17,354.62	254.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,145.00	7,271.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,479.00	8,459.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	22,820.00	FEE SCHEDULE LAB	22,676.75	8,841.00
EKG/ECG	2,513.00	203.00	MRI SERVICES	10,675.00	0.00
IV THERAPY	6,661.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,898.00	28,457.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	588.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,173.00	665.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,758.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,355.37	8,279.27
RADIOLOGY THERAPEUTIC	24,042.00	2,740.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,672.00	0.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	14,880.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,698.00	2,092.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,913.00	0.00	IMPL DEV CHARGE PATIENTS	7,546.84	1,700.00
LITHOTRIPSY	0.00	22,004.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,803.00	1,722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,718.00	3,324.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,582.00	10,182.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,674.00	48,084.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,940.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,838.00	150.00			

TOTAL ANCILLARY	307,760.90	192,135.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	307,760.90	192,135.58

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	325,331.63	ADJUSTMENTS	1,560.11
COVERED CHARGES	303,551.63	CONTRACTUAL ALLOW	290,942.71
NON-COVERD CHARGES	21,780.00	TOTAL MEDICAID LIAB	12,608.92
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	12,218.92

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,121.52	0.00	OTHER LAB	1,858.00	0.00
MED/SURG SUPPLY	10,593.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,493.00	1,044.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,666.00	6,603.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,549.00	2,478.00
EKG/ECG	5,075.00	0.00	MRI SERVICES	4,012.00	0.00
IV THERAPY	4,908.00	944.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,758.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,862.00	2,360.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,344.98	2,085.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	4,410.00	IMPL DEV CHARGE PATIENTS	1,313.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,351.00	748.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	678.00	1,108.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,491.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,568.00	0.00			

TOTAL ANCILLARY	303,551.63	21,780.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	303,551.63	21,780.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,892.32	ADJUSTMENTS	0.00
COVERED CHARGES	9,966.32	CONTRACTUAL ALLOW	2,629.41
NON-COVERD CHARGES	2,926.00	TOTAL MEDICAID LIAB	7,336.91
		LESS: COB	7,330.91
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	189.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,543.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,236.00	145.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,976.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.00	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	490.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	808.00	748.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,966.32	2,926.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,966.32	2,926.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,593,709.81	ADJUSTMENTS	468,508.16
COVERED CHARGES	13,024,524.51	CONTRACTUAL ALLOW	10,908,459.80
NON-COVERD CHARGES	569,185.30	TOTAL MEDICAID LIAB	2,116,064.71
		LESS: COB	9,129.10
		LESS: COPAYMENT	1,683.95
		REIMBURSEMENT	2,105,251.66

TOTAL NUMBER OF CLAIMS 369

GEORGIA 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232,634.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	542,272.39	358.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,027.00	32,904.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,830.00	1,893.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,445.00	1,610.11	FEE SCHEDULE LAB	103,680.00	8,966.00
EKG/ECG	12,992.00	4,669.00	MRI SERVICES	0.00	0.00
IV THERAPY	365,845.00	15,595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,368,677.10	128,014.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	721.00	428.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	366,987.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,659.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,759.00	674.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	303,829.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,877,949.17	279,052.18
RADIOLOGY THERAPEUTIC	215,951.32	7,362.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,430.00	1,807.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,918,123.36	0.00
LITHOTRIPSY	44,008.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,808.00	724.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	906.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,633.00	6,541.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	437,474.00	77,692.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,884.00	895.00			

TOTAL ANCILLARY	13,024,524.51	569,185.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,024,524.51	569,185.30

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	143,066.57	ADJUSTMENTS	0.00
COVERED CHARGES	74,771.57	CONTRACTUAL ALLOW	-34,769.79
NON-COVERD CHARGES	68,295.00	TOTAL MEDICAID LIAB	109,541.36
		LESS: COB	109,484.36
		LESS: COPAYMENT	57.00
		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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	570.00	143.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,376.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	405.00	27.00
EKG/ECG	203.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,179.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,273.00	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	3,305.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,117.00	0.00
RADIOLOGY THERAPEUTIC	44,038.00	18,250.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	49,875.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,771.57	68,295.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,771.57	68,295.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,289,025.45	ADJUSTMENTS	29,001.68
COVERED CHARGES	7,114,538.45	CONTRACTUAL ALLOW	5,399,965.28
NON-COVERD CHARGES	174,487.00	TOTAL MEDICAID LIAB	1,714,573.17
		LESS: COB	2,201.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,712,372.02

TOTAL NUMBER OF ADMISSIONS 255

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	592	0	690,272.00	130,172.00
ROUTINE NURSERY	88	0	86,883.00	1,188.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	1.00
TOTAL ROUTINE	680	0	777,155.00	131,361.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	136	0	539,723.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	136	0	539,723.00	0.00
TOTAL ACCOMODATIONS	816	0	1,316,878.00	131,361.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	824,326.52	0.00	OTHER LAB	100,868.00	0.00
MED/SURG SUPPLY	81,591.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,119,226.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	738,594.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,429.07	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	83,317.00	0.00	MRI SERVICES	96,749.00	0.00
IV THERAPY	53,192.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	332,193.00	0.00	DURABLE MED. EQUIP.	0.00	132.00
LABOR/DELIVERY ROOM	159,676.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,713.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	70,476.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	672,832.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,437.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	567.00	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	12,237.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	37,926.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,846.00	2,112.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	95,699.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,996.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,915.00	33,972.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,764.00	6,910.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	209,449.00	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	96,117.20	0.00			

TOTAL ANCILLARY	5,797,660.45	43,126.00
TOTAL ACCOMODATIONS	1,316,878.00	131,361.00
TOTAL CHARGES	7,114,538.45	174,487.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,769.86	ADJUSTMENTS	0.00
COVERED CHARGES	64,121.86	CONTRACTUAL ALLOW	48,773.85
NON-COVERD CHARGES	648.00	TOTAL MEDICAID LIAB	15,348.01
		LESS: COB	15,348.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	3,498.00	648.00
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	3,498.00	648.00
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	3,498.00	648.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,381.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,627.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	603.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	986.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,118.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,770.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,660.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,459.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,064.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,007.40	0.00			

TOTAL ANCILLARY	60,623.86	0.00
TOTAL ACCOMODATIONS	3,498.00	648.00
TOTAL CHARGES	64,121.86	648.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,309,126.06	ADJUSTMENTS	214,562.31
COVERED CHARGES	11,366,665.20	CONTRACTUAL ALLOW	10,099,403.78
NON-COVERD CHARGES	1,942,460.86	TOTAL MEDICAID LIAB	1,267,261.42
		LESS: COB	10,919.69
		LESS: COPAYMENT	2,317.83
		REIMBURSEMENT	1,254,023.90
		ALL OTHER	1,142,777.77
		FEE SCHEDULE-LAB	97,832.56
		INJECTABLE DRUGS	13,413.57

TOTAL NUMBER OF CLAIMS 2,710

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,073.94	0.00	OTHER LAB	181,331.00	0.00
MED/SURG SUPPLY	226,782.66	10,770.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	514,661.00	80,992.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,436,658.00	486,210.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,516.00	FEE SCHEDULE LAB	1,449,788.00	87,481.00
EKG/ECG	177,973.00	5,423.00	MRI SERVICES	321,889.00	102,636.00
IV THERAPY	237,767.00	40,043.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	747,732.00	311,292.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,542.00	0.00	REHAB THERAPY	0.00	3,150.00
RESPIRATORY SERVICES	71,466.00	15,303.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,110.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	143,152.00	34,961.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,001,979.00	131,078.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	295,852.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	167,005.30	276,950.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,381.29	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,952.00	12,156.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,109.35	85,012.20
LITHOTRIPSY	29,831.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	275,238.00	44,648.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,052.00	10,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	192,603.00	132,015.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	194,924.00	46,785.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	132,730.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,463.95	11,929.00			

TOTAL ANCILLARY	11,366,665.20	1,942,460.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,366,665.20	1,942,460.86

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	137,502.26	ADJUSTMENTS	0.00
COVERED CHARGES	93,309.80	CONTRACTUAL ALLOW	73,329.63
NON-COVERD CHARGES	44,192.46	TOTAL MEDICAID LIAB	19,980.17
		LESS: COB	19,947.17
		LESS: COPAYMENT	33.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,033.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,007.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,044.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,185.00	26,740.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,299.00	1,269.00
EKG/ECG	493.00	493.00	MRI SERVICES	9,850.00	0.00
IV THERAPY	484.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	6,368.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,700.00	778.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,762.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	644.66	461.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,975.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	119.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,604.00	2,934.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,822.00	1,788.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,149.00	3,361.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,114.40	0.00			

TOTAL ANCILLARY	93,309.80	44,192.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,309.80	44,192.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	221,375.95	ADJUSTMENTS	108.88
COVERED CHARGES	209,649.65	CONTRACTUAL ALLOW	204,838.81
NON-COVERD CHARGES	11,726.30	TOTAL MEDICAID LIAB	4,810.84
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	4,693.84
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,119.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,244.00	1,362.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,419.00	3,107.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,857.00	1,821.00
EKG/ECG	1,972.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,257.00	2,614.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	102,035.00	2,101.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,816.06	721.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,847.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	209,649.65	11,726.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	209,649.65	11,726.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,588.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,588.40	CONTRACTUAL ALLOW	1,158.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	429.60
		LESS: COB	429.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	1,578.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,588.40	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,588.40	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	77,302.20	ADJUSTMENTS	0.00
COVERED CHARGES	76,220.34	CONTRACTUAL ALLOW	65,339.14
NON-COVERD CHARGES	1,081.86	TOTAL MEDICAID LIAB	10,881.20
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	10,869.20
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	826.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,984.87	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	1,488.00	0.00
EKG/ECG	493.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	509.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,768.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,552.00	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	2,762.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,617.21	1,081.86
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,133.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,086.80	0.00			

TOTAL ANCILLARY	76,220.34	1,081.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	76,220.34	1,081.86

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	93,495,158.35	ADJUSTMENTS	3,003,063.70
COVERED CHARGES	90,314,154.75	CONTRACTUAL ALLOW	71,902,760.45
NON-COVERD CHARGES	3,181,003.60	TOTAL MEDICAID LIAB	18,411,394.30
		LESS: COB	169,941.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,241,453.19

TOTAL NUMBER OF ADMISSIONS 974

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,422	0	7,089,403.00	1,076,757.00
ROUTINE NURSERY	305	0	514,823.00	69,712.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	5.00
TOTAL ROUTINE	5,727	0	7,604,226.00	1,146,474.00
SPECIAL CARE SERVICES				
CCU	359	0	1,391,843.00	0.00
ICU	1,087	0	4,563,274.00	0.00
NICU	26	0	100,958.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,056,075.00	0.00
TOTAL ACCOMODATIONS	7,199	0	13,660,301.00	1,146,474.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,380,289.65	414,710.35	OTHER LAB	584,778.00	0.00
MED/SURG SUPPLY	4,384,101.07	697,192.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,829,363.00	136,685.00	EDUCATION & TRAINING	12,384.00	0.00
RADIOLOGY-DIAGNOSTIC	1,844,223.00	11,417.00	OTHER THERAPEUTIC SVC	0.00	1,860.00
CT SCAN	3,247,089.00	64,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	664,976.29	4,556.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	542,737.00	503.00	MRI SERVICES	747,943.00	6,816.00
IV THERAPY	1,740.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,963,658.50	24,535.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,179.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,265,772.00	10,557.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,466,601.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,106,129.00	3,066.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,920,906.00	7,239.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	814,619.00	7,768.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	315,545.00	619.00	INJECTABLE DRUGS	432.86	0.00
RADIOLOGY THERAPEUTIC	322,486.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	278,702.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	265,216.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,180,758.00	57,420.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,770.00	8,498.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,053,877.00	1,388.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	50,664.00
OTHER IMAGING SERVICE	680,698.00	12,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,447,706.00	477,827.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	136,638.00	28,149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,176,116.00	5,405.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,971.00	0.00			
ORGAN ACQUISITION	2,515,406.00	0.00			
TREATMENT/OBSERV. RM	370,042.04	0.00			

TOTAL ANCILLARY	76,653,853.75	2,034,529.60
TOTAL ACCOMODATIONS	13,660,301.00	1,146,474.00
TOTAL CHARGES	90,314,154.75	3,181,003.60

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 07/01/17 THROUGH 06/30/18
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	2017325052242	11/09/17 - 11/17/17	11/27/17	0.00	4,889.00	0.00	0.00	0.00
614	2018032055939	11/30/17 - 12/10/17	02/05/18	0.00	5,771.00	0.00	0.00	0.00
614	2018050009933	01/27/18 - 02/14/18	02/26/18	0.00	4,889.00	0.00	0.00	0.00
614	2018115039049	03/28/18 - 04/22/18	04/30/18	0.00	4,889.00	0.00	0.00	0.00
614	2018138051603	12/15/17 - 12/23/17	05/21/18	0.00	4,889.00	0.00	0.00	0.00
614	2318165000213	02/19/18 - 02/27/18	06/25/18	0.00	4,889.00	0.00	4,021.38	0.00
948	2218187012021	05/25/18 - 06/03/18	07/09/18	0.00	446.00	0.00	0.00	0.00
614	2018191047632	06/09/18 - 07/06/18	07/16/18	0.00	4,889.00	0.00	0.00	0.00
614	5218282000118	05/10/18 - 07/18/18	10/15/18	0.00	4,889.00	0.00	0.00	0.00
614	5218345000134	02/06/18 - 02/16/18	12/17/18	0.00	4,889.00	0.00	0.00	0.00
-1	2319044000048	05/25/18 - 06/02/18	02/25/19	0.00	446.00	0.00	1,904.76	0.00
614	2019135048118	12/22/17 - 01/06/18	05/20/19	0.00	4,889.00	0.00	0.00	0.00
TOTAL				0.00	50,664.00	0.00	5,926.14	0.00

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,870,292.71	ADJUSTMENTS	0.00
COVERED CHARGES	1,826,924.71	CONTRACTUAL ALLOW	1,075,650.05
NON-COVERD CHARGES	43,368.00	TOTAL MEDICAID LIAB	751,274.66
		LESS: COB	751,274.66
		LESS: COPAYMENT	0.00
		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	159	0	209,085.00	28,734.00
ROUTINE NURSERY	30	0	60,029.00	12,699.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	189	0	269,114.00	41,433.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	24	0	102,468.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	102,468.00	0.00
TOTAL ACCOMODATIONS	213	0	371,582.00	41,433.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329,134.81	0.00	OTHER LAB	17,187.00	0.00
MED/SURG SUPPLY	51,594.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	253,535.00	0.00	EDUCATION & TRAINING	172.00	0.00
RADIOLOGY-DIAGNOSTIC	30,755.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,331.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,761.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,048.00	0.00	MRI SERVICES	12,180.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,330.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,985.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,482.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,923.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,552.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,795.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,483.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	56,727.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	466.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,584.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,198.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,248.00	1,535.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,604.00	400.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,645.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,222.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,491.00	0.00			

TOTAL ANCILLARY	1,455,342.71	1,935.00
TOTAL ACCOMODATIONS	371,582.00	41,433.00
TOTAL CHARGES	1,826,924.71	43,368.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,148,597.39	ADJUSTMENTS	542,334.13
COVERED CHARGES	17,042,765.06	CONTRACTUAL ALLOW	14,820,183.77
NON-COVERD CHARGES	7,105,832.33	TOTAL MEDICAID LIAB	2,222,581.29
		LESS: COB	91,917.95
		LESS: COPAYMENT	5,589.23
		REIMBURSEMENT	2,125,074.11
		ALL OTHER	1,844,944.92
		FEE SCHEDULE-LAB	198,559.22
		INJECTABLE DRUGS	81,569.97

TOTAL NUMBER OF CLAIMS 3,903

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,333.99	923.92
MED/SURG SUPPLY	518,045.50	305,777.75
LABORATORY-GENERAL	0.00	164.00
RADIOLOGY-DIAGNOSTIC	597,183.00	95,684.00
CT SCAN	2,076,271.00	699,425.00
PHYSICAL THERAPY	2,698.00	9,168.06
EKG/ECG	273,313.00	5,533.00
IV THERAPY	21,744.00	0.00
OPERATING ROOM	1,266,268.00	541,865.00
LABOR/DELIVERY ROOM	12,849.00	0.00
RESPIRATORY SERVICES	162,970.00	75,387.00
ANESTHESIA	208,923.00	1,648.00
GI SERVICES	428,319.00	211,299.00
EMERGENCY ROOM	3,195,985.00	142,780.00
RECOVERY ROOM	283,566.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	394,063.00	843,019.00
OCCUPATIONAL THERAPY	0.00	3,354.00
SPEECH PATHOLOGY	1,414.00	5,026.00
RENAL DIALYSIS	0.00	68,904.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	235,279.00	117,065.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	364,763.00	135,726.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	221,964.00	72,086.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	174,865.00	274,402.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,038,183.00	643,116.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	306,353.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	282,206.02	9,811.00
OTHER LAB	242,508.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	1,032.00
OTHER THERAPEUTIC SVC	0.00	620.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,104,604.00	338,721.00
MRI SERVICES	636,019.00	168,413.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	653,921.48	1,771,511.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	105,154.07	510,952.63
NO CC/INVALID REV CODE	0.00	52,418.00

TOTAL ANCILLARY	17,042,765.06	7,105,832.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,042,765.06	7,105,832.33

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017282013066	10/06/17 - 10/06/17	10/16/17	0.00	4,490.00	0.00	0.00	0.00
614	2017282013066	10/06/17 - 10/06/17	10/16/17	0.00	399.00	0.00	0.00	0.00
614	2017282013068	10/05/17 - 10/05/17	10/16/17	0.00	5,372.00	0.00	0.00	0.00
614	2017282013068	10/05/17 - 10/05/17	10/16/17	0.00	399.00	0.00	0.00	0.00
614	2017289015232	10/11/17 - 10/11/17	10/23/17	0.00	4,490.00	0.00	0.00	0.00
614	2017289015232	10/11/17 - 10/11/17	10/23/17	0.00	399.00	0.00	0.00	0.00
614	2018078014846	03/14/18 - 03/14/18	03/26/18	0.00	5,372.00	0.00	0.00	0.00
614	2018078014846	03/14/18 - 03/14/18	03/26/18	0.00	399.00	0.00	0.00	0.00
614	5918107001347	04/09/18 - 04/09/18	04/23/18	0.00	8,980.00	0.00	0.00	0.00
614	5918107001347	04/09/18 - 04/09/18	04/23/18	0.00	798.00	0.00	0.00	0.00
614	2018137059215	05/14/18 - 05/14/18	05/21/18	0.00	4,490.00	0.00	0.00	0.00
614	2018137059215	05/14/18 - 05/14/18	05/21/18	0.00	399.00	0.00	0.00	0.00
614	2018138052880	05/14/18 - 05/14/18	05/21/18	0.00	5,372.00	0.00	0.00	0.00
614	2018138052880	05/14/18 - 05/14/18	05/21/18	0.00	399.00	0.00	0.00	0.00
614	5918169001259	06/11/18 - 06/11/18	06/25/18	0.00	4,490.00	0.00	0.00	0.00
614	5918169001259	06/11/18 - 06/11/18	06/25/18	0.00	399.00	0.00	0.00	0.00
614	2218192004274	06/14/18 - 06/14/18	07/16/18	0.00	5,372.00	0.00	0.00	0.00
614	2218192004274	06/14/18 - 06/14/18	07/16/18	0.00	399.00	0.00	0.00	0.00
TOTAL				0.00	52,418.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	489,980.85	ADJUSTMENTS	0.00
COVERED CHARGES	305,037.17	CONTRACTUAL ALLOW	187,804.05
NON-COVERD CHARGES	184,943.68	TOTAL MEDICAID LIAB	117,233.12
		LESS: COB	117,137.12
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,301.29	0.00	OTHER LAB	7,552.00	0.00
MED/SURG SUPPLY	17,759.78	8,316.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,595.00	598.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,180.00	14,775.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,533.00	7,850.00
EKG/ECG	4,024.00	0.00	MRI SERVICES	6,673.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,504.00	83,998.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,575.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,149.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,009.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,689.00	6,630.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,839.00	1,812.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,277.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,874.10	3,559.72
RADIOLOGY THERAPEUTIC	278.00	8,852.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,121.00	2,341.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	38,468.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,661.00	6,793.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,727.00	68.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,048.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,495.00	882.00			

TOTAL ANCILLARY	305,037.17	184,943.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	305,037.17	184,943.68

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	269,476.44	ADJUSTMENTS	52.94
COVERED CHARGES	230,591.53	CONTRACTUAL ALLOW	218,266.76
NON-COVERD CHARGES	38,884.91	TOTAL MEDICAID LIAB	12,324.77
		LESS: COB	6,055.94
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	5,995.83
		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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,715.84	0.00	OTHER LAB	1,487.00	0.00
MED/SURG SUPPLY	1,010.24	324.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,275.00	1,251.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,738.00	23,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,891.00	2,590.00
EKG/ECG	3,018.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,348.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	264.00	138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,779.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	147,082.00	1,929.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,872.75	1,790.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	184.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,926.00	7,782.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	230,591.53	38,884.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	230,591.53	38,884.91

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,527.20	ADJUSTMENTS	0.00
COVERED CHARGES	18,762.20	CONTRACTUAL ALLOW	12,468.02
NON-COVERD CHARGES	12,765.00	TOTAL MEDICAID LIAB	6,294.18
		LESS: COB	6,279.18
		LESS: COPAYMENT	15.00
		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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,196.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,417.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,747.00	160.00
EKG/ECG	1,006.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,787.00	306.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	390.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,357.00	882.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	18,762.20	12,765.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,762.20	12,765.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,969,824.13	ADJUSTMENTS	93,829.42
COVERED CHARGES	2,504,353.49	CONTRACTUAL ALLOW	2,255,271.10
NON-COVERD CHARGES	465,470.64	TOTAL MEDICAID LIAB	249,082.39
		LESS: COB	5,257.50
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	243,536.89

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,094.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	178,235.75	149,364.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	172.00
RADIOLOGY-DIAGNOSTIC	7,357.00	85,458.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,122.00	13,882.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,050.00	FEE SCHEDULE LAB	36,441.00	1,293.00
EKG/ECG	2,012.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,262.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	622,925.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90,083.00	264.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,029.00	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	34,719.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	409,626.85	41,877.58
RADIOLOGY THERAPEUTIC	264,098.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,201.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,828.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	684.00	233.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,231.72	109,894.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,772.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,496.00	2,334.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	363,292.00	54,619.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,872.40	0.00			

TOTAL ANCILLARY	2,504,353.49	465,470.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,504,353.49	465,470.64

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	69,364.25	ADJUSTMENTS	5,517.34
COVERED CHARGES	68,814.25	CONTRACTUAL ALLOW	54,929.44
NON-COVERD CHARGES	550.00	TOTAL MEDICAID LIAB	13,884.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,884.81

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8	0	4,400.00	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	8	0	4,400.00	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	8	0	4,400.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,272.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,610.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,943.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,144.00	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	1,685.00	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	11,245.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,110.00	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	11,446.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,959.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	550.00			

TOTAL ANCILLARY	64,414.25	550.00
TOTAL ACCOMODATIONS	4,400.00	0.00
TOTAL CHARGES	68,814.25	550.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,847,607.21	ADJUSTMENTS	173,590.03
COVERED CHARGES	6,639,077.46	CONTRACTUAL ALLOW	5,603,277.27
NON-COVERD CHARGES	208,529.75	TOTAL MEDICAID LIAB	1,035,800.19
		LESS: COB	0.00
		LESS: COPAYMENT	978.00
		REIMBURSEMENT	1,034,822.19
		ALL OTHER	934,780.32
		FEE SCHEDULE-LAB	84,338.54
		INJECTABLE DRUGS	15,703.33

TOTAL NUMBER OF CLAIMS 2,313

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,130.75	0.00	OTHER LAB	8,915.00	0.00
MED/SURG SUPPLY	247,198.96	2,642.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	368.00	0.00
RADIOLOGY-DIAGNOSTIC	370,174.00	6,085.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	569,522.00	12,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,234,773.00	45,417.00
EKG/ECG	117,613.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	35,548.00	1,600.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,933.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,547.00	25,227.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,485.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,462,444.00	75,508.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	297,529.75	12,091.75
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	13,835.00	4,570.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,260.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,253.00	610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	489.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,979.00	12,295.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,635.00	10,220.00			

TOTAL ANCILLARY	6,639,077.46	208,529.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,639,077.46	208,529.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,306.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,134.00	CONTRACTUAL ALLOW	19,919.40
NON-COVERD CHARGES	5,172.00	TOTAL MEDICAID LIAB	17,214.60
		LESS: COB	17,214.16
		LESS: COPAYMENT	0.44
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,689.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,020.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,771.00	152.00
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	24,653.00	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	2,097.50	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	152.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	37,134.00	5,172.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,134.00	5,172.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC
2360 ROCKMART HWY
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	342,751.00	ADJUSTMENTS	1,120.00
COVERED CHARGES	340,525.00	CONTRACTUAL ALLOW	331,725.00
NON-COVERD CHARGES	2,226.00	TOTAL MEDICAID LIAB	8,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	8,527.00
		TOTAL NUMBER OF CLAIMS	176

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	706.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,967.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,729.00	795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,264.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,623.00	879.00
EKG/ECG	2,022.00	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	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	262,622.00	380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,607.75	172.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	73.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	340,525.00	2,226.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	340,525.00	2,226.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,420.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,293.00	CONTRACTUAL ALLOW	3,203.96
NON-COVERD CHARGES	127.00	TOTAL MEDICAID LIAB	2,089.04
		LESS: COB	2,083.04
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	126.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.00	127.00
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	4,734.00	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	166.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,293.00	127.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,293.00	127.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	169,079.50	ADJUSTMENTS	19,391.56
COVERED CHARGES	162,724.50	CONTRACTUAL ALLOW	138,410.05
NON-COVERD CHARGES	6,355.00	TOTAL MEDICAID LIAB	24,314.45
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	24,218.45

TOTAL NUMBER OF CLAIMS 5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,162.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,795.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,389.00	922.00
EKG/ECG	674.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,940.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,636.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	862.00	4,738.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,790.00	650.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	978.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,008.25	45.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	24,069.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,390.00	0.00			

TOTAL ANCILLARY	162,724.50	6,355.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	162,724.50	6,355.00

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	170,712.50	ADJUSTMENTS	22,923.76
COVERED CHARGES	163,391.67	CONTRACTUAL ALLOW	73,333.44
NON-COVERD CHARGES	7,320.83	TOTAL MEDICAID LIAB	90,058.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,058.23

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	46	0	16,100.00	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	46	0	16,100.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	18	0	12,150.00	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	18	0	12,150.00	0.00
TOTAL ACCOMODATIONS	64	0	28,250.00	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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,992.00	0.00	OTHER LAB	1,954.96	0.00
MED/SURG SUPPLY	12,903.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,529.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,091.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,511.62	7,117.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,606.89	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	13,814.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,436.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,176.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	337.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	754.14	203.53			
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	1,382.18	0.00			

TOTAL ANCILLARY	135,141.67	7,320.83
TOTAL ACCOMODATIONS	28,250.00	0.00
TOTAL CHARGES	163,391.67	7,320.83

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	783,612.98	ADJUSTMENTS	36,625.55
COVERED CHARGES	683,445.00	CONTRACTUAL ALLOW	382,491.00
NON-COVERD CHARGES	100,167.98	TOTAL MEDICAID LIAB	300,954.00
		LESS: COB	220.52
		LESS: COPAYMENT	456.00
		REIMBURSEMENT	300,277.48
		ALL OTHER	274,269.53
		FEE SCHEDULE-LAB	21,669.48
		INJECTABLE DRUGS	4,338.47

TOTAL NUMBER OF CLAIMS 620

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,915.40	1,613.20	OTHER LAB	28,535.79	0.00
MED/SURG SUPPLY	25,959.95	789.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,480.78	5,384.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	125,375.38	52,544.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	639.00	273.00	FEE SCHEDULE LAB	111,210.85	8,750.21
EKG/ECG	9,728.25	0.00	MRI SERVICES	5,189.20	2,227.17
IV THERAPY	6,461.30	2,671.14	PROFESSIONAL FEES	0.00	990.00
OPERATING ROOM	8,711.86	2,595.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,049.19	1,212.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,249.60	896.84	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	173,340.10	4,372.46	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,300.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,372.70	4,910.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	165.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69.63	564.55	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,279.28	2,518.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,147.77	1,628.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,070.00	5,560.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,828.67	314.85			

TOTAL ANCILLARY	683,445.00	99,817.98
TOTAL ACCOMODATIONS	0.00	350.00
TOTAL CHARGES	683,445.00	100,167.98

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,529.52	ADJUSTMENTS	0.00
COVERED CHARGES	280.00	CONTRACTUAL ALLOW	48.11
NON-COVERD CHARGES	2,249.52	TOTAL MEDICAID LIAB	231.89
		LESS: COB	228.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	2,249.52	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	280.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	280.00	2,249.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	280.00	2,249.52

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	48,373.71	ADJUSTMENTS	1,068.02
COVERED CHARGES	47,393.62	CONTRACTUAL ALLOW	43,736.73
NON-COVERD CHARGES	980.09	TOTAL MEDICAID LIAB	3,656.89
		LESS: COB	23.92
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	3,482.97
		TOTAL NUMBER OF CLAIMS	74

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	964.00	0.00	OTHER LAB	332.08	0.00
MED/SURG SUPPLY	931.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,586.66	525.97	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,412.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,209.29	354.12
EKG/ECG	796.51	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	25,488.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,362.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	310.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	47,393.62	980.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,393.62	980.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	14,751.51	ADJUSTMENTS	0.00
COVERED CHARGES	14,176.51	CONTRACTUAL ALLOW	9,313.62
NON-COVERD CHARGES	575.00	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,288.27	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	30.08	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	1,966.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,921.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	645.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	390.00	575.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,176.51	575.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,176.51	575.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,502,927.01	ADJUSTMENTS	28,485.30
COVERED CHARGES	1,472,967.26	CONTRACTUAL ALLOW	650,667.38
NON-COVERD CHARGES	29,959.75	TOTAL MEDICAID LIAB	822,299.88
		LESS: COB	12,567.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	809,732.02

TOTAL NUMBER OF ADMISSIONS 140

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	255	0	132,600.00	18,400.00
ROUTINE NURSERY	42	0	21,840.00	5,774.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	297	0	154,440.00	24,174.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	123	0	162,979.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	162,979.00	0.00
TOTAL ACCOMODATIONS	420	0	317,419.00	24,174.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,501.00	0.00	OTHER LAB	8,568.00	0.00
MED/SURG SUPPLY	71,040.73	394.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	184,602.36	0.00	EDUCATION & TRAINING	2.00	0.00
RADIOLOGY-DIAGNOSTIC	23,803.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,805.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,171.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,977.00	0.00	MRI SERVICES	25,839.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,323.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,520.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,050.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,593.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,771.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,908.00	0.00	INJECTABLE DRUGS	115,325.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	868.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	18,726.00	2,340.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	137.50	151.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,207.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,540.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,569.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,671.00	2,899.50			
AUDIOLOGY	5,265.00	0.00			
CARDIOLOGY	29,289.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,412.00	0.00			

TOTAL ANCILLARY	1,155,548.26	5,785.75
TOTAL ACCOMODATIONS	317,419.00	24,174.00
TOTAL CHARGES	1,472,967.26	29,959.75

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,745,246.83	ADJUSTMENTS	95,789.41
COVERED CHARGES	1,706,740.28	CONTRACTUAL ALLOW	1,333,427.14
NON-COVERD CHARGES	38,506.55	TOTAL MEDICAID LIAB	373,313.14
		LESS: COB	678.96
		LESS: COPAYMENT	1,284.00
		REIMBURSEMENT	371,350.18
		ALL OTHER	311,080.12
		FEE SCHEDULE-LAB	56,049.57
		INJECTABLE DRUGS	4,220.49

TOTAL NUMBER OF CLAIMS 1,698

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,933.31	1,130.00	OTHER LAB	29,414.50	0.00
MED/SURG SUPPLY	45,468.75	300.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,591.50	1,080.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	191,637.50	1,152.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,026.75	719.50	FEE SCHEDULE LAB	336,563.90	6,850.00
EKG/ECG	23,202.00	639.00	MRI SERVICES	93,877.50	1,785.00
IV THERAPY	7,693.00	440.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	156,408.64	9,344.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,332.00	212.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,131.00	311.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,591.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	47,893.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	318,159.71	1,572.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,339.00	5,583.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	140.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,340.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,660.50	605.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	854.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,701.50	1,219.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,782.00	572.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,205.50	0.00			
AUDIOLOGY	0.00	292.50			
CARDIOLOGY	24,094.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,028.62	2,357.00			

TOTAL ANCILLARY	1,706,740.28	38,506.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,706,740.28	38,506.55

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,868.20	ADJUSTMENTS	0.00
COVERED CHARGES	26,739.70	CONTRACTUAL ALLOW	13,963.54
NON-COVERD CHARGES	2,128.50	TOTAL MEDICAID LIAB	12,776.16
		LESS: COB	12,755.16
		LESS: COPAYMENT	21.00
		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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,732.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	586.50	109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,594.00	216.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,608.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,012.00	0.00	FEE SCHEDULE LAB	3,971.20	204.00
EKG/ECG	396.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	859.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	636.00	258.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.50	58.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,824.50	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	390.00	944.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,716.50	339.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,365.50	0.00			

TOTAL ANCILLARY	26,739.70	2,128.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,739.70	2,128.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,812.50	ADJUSTMENTS	320.64
COVERED CHARGES	74,989.00	CONTRACTUAL ALLOW	69,378.17
NON-COVERD CHARGES	823.50	TOTAL MEDICAID LIAB	5,610.83
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	5,391.83
		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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,556.00	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	644.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,119.00	286.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,691.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,736.50	125.00
EKG/ECG	938.00	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	291.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,816.00	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	1,791.00	400.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	406.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,989.00	823.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	74,989.00	823.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,922.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,865.50	CONTRACTUAL ALLOW	894.38
NON-COVERD CHARGES	57.00	TOTAL MEDICAID LIAB	971.12
		LESS: COB	962.12
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.00	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	152.00	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	24.00	17.00
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	1,564.50	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	40.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,865.50	57.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,865.50	57.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	362,256.95	ADJUSTMENTS	0.00
COVERED CHARGES	330,936.27	CONTRACTUAL ALLOW	215,115.98
NON-COVERD CHARGES	31,320.68	TOTAL MEDICAID LIAB	115,820.29
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	115,820.29

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	65	0	43,375.00	21,094.00
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	65	0	43,375.00	21,094.00
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	65	0	43,375.00	21,094.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,798.54	0.00	OTHER LAB	2,570.88	0.00
MED/SURG SUPPLY	23,911.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,954.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,958.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,220.80	1,330.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	465.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,715.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,641.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,600.00	5,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,197.76	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	14,656.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,406.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	470.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,047.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	954.72	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,016.44	3,696.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,116.80	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	13,776.68	0.00			

TOTAL ANCILLARY	287,561.27	10,226.68
TOTAL ACCOMODATIONS	43,375.00	21,094.00
TOTAL CHARGES	330,936.27	31,320.68

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	857,001.84	ADJUSTMENTS	64,468.76
COVERED CHARGES	629,724.71	CONTRACTUAL ALLOW	435,950.28
NON-COVERD CHARGES	227,277.13	TOTAL MEDICAID LIAB	193,774.43
		LESS: COB	192.52
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	193,035.91
		ALL OTHER	174,287.62
		FEE SCHEDULE-LAB	17,577.73
		INJECTABLE DRUGS	1,170.56

TOTAL NUMBER OF CLAIMS 527

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,234.83	4,352.81	OTHER LAB	7,675.64	0.00
MED/SURG SUPPLY	40,977.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,660.56	6,947.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,582.48	108,289.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	825.36	FEE SCHEDULE LAB	161,321.80	13,629.96
EKG/ECG	9,612.64	1,962.24	MRI SERVICES	2,571.92	0.00
IV THERAPY	65,539.24	9,272.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,235.52	19,980.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,237.44	3,713.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	103,454.00	15,847.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,240.14	35,389.62
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,686.76	1,954.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,118.96	591.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,739.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,375.32	781.22			

TOTAL ANCILLARY	629,724.71	227,277.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	629,724.71	227,277.13

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,396.81	ADJUSTMENTS	0.00
COVERED CHARGES	628.16	CONTRACTUAL ALLOW	46.72
NON-COVERD CHARGES	3,768.65	TOTAL MEDICAID LIAB	581.44
		LESS: COB	576.35
		LESS: COPAYMENT	5.09
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	20.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,217.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,530.32	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	589.12	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	628.16	3,768.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	628.16	3,768.65

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	39,203.95	ADJUSTMENTS	1,312.00
COVERED CHARGES	31,961.15	CONTRACTUAL ALLOW	29,781.15
NON-COVERD CHARGES	7,242.80	TOTAL MEDICAID LIAB	2,180.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	2,108.00
		TOTAL NUMBER OF CLAIMS	34

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	633.88	179.06	OTHER LAB	608.40	0.00
MED/SURG SUPPLY	1,039.19	6.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	638.00	373.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,086.80	4,963.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,364.88	1,076.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,800.39	146.26	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	13,077.84	149.76	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,711.77	348.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	31,961.15	7,242.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,961.15	7,242.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,861.06	ADJUSTMENTS	4,669.86
COVERED CHARGES	28,168.72	CONTRACTUAL ALLOW	18,817.00
NON-COVERD CHARGES	5,692.34	TOTAL MEDICAID LIAB	9,351.72
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,345.72
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	712.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	378.63	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	3,481.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,304.16	328.64
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,728.60	610.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	644.80	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	1,320.12	1,271.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,080.00	0.00			

TOTAL ANCILLARY	28,168.72	5,692.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,168.72	5,692.34

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	54,583,505.37	ADJUSTMENTS	611,240.89
COVERED CHARGES	53,730,597.56	CONTRACTUAL ALLOW	44,863,460.33
NON-COVERD CHARGES	852,907.81	TOTAL MEDICAID LIAB	8,867,137.23
		LESS: COB	52,691.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,814,445.46

TOTAL NUMBER OF ADMISSIONS 662

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,219	0	2,403,362.84	602,703.16
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	3,219	0	2,403,362.84	602,703.16
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	726	0	1,933,559.19	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	726	0	1,933,559.19	0.00
TOTAL ACCOMODATIONS	3,945	0	4,336,922.03	602,703.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,360,119.15	0.00	OTHER LAB	380,632.60	0.00
MED/SURG SUPPLY	3,074,753.11	1,250.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,063,142.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,185,866.48	988.20	OTHER THERAPEUTIC SVC	0.00	18,863.10
CT SCAN	3,294,953.88	42,812.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	774,029.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	521,742.08	0.00	MRI SERVICES	595,219.00	0.00
IV THERAPY	135,620.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,508,711.30	48,868.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,875,310.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	895,628.90	0.00	AMBULANCE	0.00	3,889.15
GI SERVICES	92,408.80	3,444.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,743,640.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	421,813.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	30,944.10
LABORATORY PATHOLOGIC	298,112.32	0.00	INJECTABLE DRUGS	3,659,137.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	428,070.41	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	100,180.48	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	229,714.68	14,693.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,789.75	442.00	TRAUMA RESPONSE	0.00	20,790.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,234,482.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	484,010.10	25,980.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	408,975.60	37,238.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	392,357.68	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,086,865.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,101.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	111,285.66	0.00			

TOTAL ANCILLARY	49,393,675.53	250,204.65
TOTAL ACCOMODATIONS	4,336,922.03	602,703.16
TOTAL CHARGES	53,730,597.56	852,907.81

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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	2017335089442	10/12/17 - 11/07/17	12/11/17	0.00	0.00	0.00	0.00	0.00
24	2019122093837	06/26/18 - 07/20/18	05/06/19	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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,576,779.09	ADJUSTMENTS	171,841.33
COVERED CHARGES	22,352,494.08	CONTRACTUAL ALLOW	20,565,290.11
NON-COVERD CHARGES	3,224,285.01	TOTAL MEDICAID LIAB	1,787,203.97
		LESS: COB	0.00
		LESS: COPAYMENT	4,873.97
		REIMBURSEMENT	1,782,330.00
		ALL OTHER	1,630,986.34
		FEE SCHEDULE-LAB	142,830.78
		INJECTABLE DRUGS	8,512.88

TOTAL NUMBER OF CLAIMS 3,509

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,926.00	221,685.10	OTHER LAB	130,386.30	0.00
MED/SURG SUPPLY	564,580.50	76,895.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,175,374.96	214,768.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,559,859.20	589,449.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,305.30	156,922.80	FEE SCHEDULE LAB	5,791,804.88	309,590.53
EKG/ECG	486,571.52	613.44	MRI SERVICES	171,688.10	67,041.80
IV THERAPY	923,402.71	105,766.14	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,058,486.30	315,071.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	287.10
RESPIRATORY SERVICES	56,070.50	387.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	379,974.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	101,609.10	35,729.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,585,427.24	21,743.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	229,534.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181,984.24	166,705.59
RADIOLOGY THERAPEUTIC	25,400.00	2,094.40	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	55,154.70	33,502.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	9,036.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,223.88	3,629.11	TRAUMA RESPONSE	0.00	115,830.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	198,916.00	29,350.00
LITHOTRIPSY	182,985.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	128,659.30	41,438.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,106.00	8,561.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	627,399.44	247,118.88			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	885,151.50	400,661.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,167.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	311,344.23	50,404.77			

TOTAL ANCILLARY	22,352,494.08	3,224,285.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,352,494.08	3,224,285.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	341,093.29	ADJUSTMENTS	0.00
COVERED CHARGES	223,546.13	CONTRACTUAL ALLOW	139,268.25
NON-COVERD CHARGES	117,547.16	TOTAL MEDICAID LIAB	84,277.88
		LESS: COB	84,247.88
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,194.21	950.92	OTHER LAB	3,823.90	0.00
MED/SURG SUPPLY	5,052.00	243.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,663.24	1,654.56	OTHER THERAPEUTIC SVC	0.00	4,265.80
CT SCAN	17,328.60	23,026.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	517.00	FEE SCHEDULE LAB	52,965.07	5,846.44
EKG/ECG	5,475.52	613.44	MRI SERVICES	0.00	6,200.00
IV THERAPY	3,773.24	609.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,539.30	16,588.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	990.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,710.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,079.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,076.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	579.09	846.73
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	100.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,550.00	0.00
LITHOTRIPSY	0.00	40,256.70	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,797.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,703.72			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,751.80	6,100.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,644.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,110.24	1,024.00			

TOTAL ANCILLARY	223,546.13	117,547.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	223,546.13	117,547.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	902,659.23	ADJUSTMENTS	161.82
COVERED CHARGES	847,880.54	CONTRACTUAL ALLOW	834,678.70
NON-COVERD CHARGES	54,778.69	TOTAL MEDICAID LIAB	13,201.84
		LESS: COB	0.00
		LESS: COPAYMENT	549.00
		REIMBURSEMENT	12,652.84
		TOTAL NUMBER OF CLAIMS	236

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,875.26	6,649.41	OTHER LAB	7,513.80	0.00
MED/SURG SUPPLY	1,400.00	432.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,241.60	12,147.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	197,332.64	21,080.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	237,806.03	7,211.24
EKG/ECG	11,246.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,423.42	505.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,426.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,485.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	293,196.28	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	2,879.31	4,832.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,054.80	1,920.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	847,880.54	54,778.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	847,880.54	54,778.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,665.70	ADJUSTMENTS	0.00
COVERED CHARGES	16,009.35	CONTRACTUAL ALLOW	10,371.36
NON-COVERD CHARGES	8,656.35	TOTAL MEDICAID LIAB	5,637.99
		LESS: COB	5,628.99
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	752.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,862.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,195.84	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	428.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,286.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.04	41.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,009.35	8,656.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,009.35	8,656.35

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

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,254,223.22	ADJUSTMENTS	5,332.98
COVERED CHARGES	4,084,895.62	CONTRACTUAL ALLOW	3,911,346.30
NON-COVERD CHARGES	169,327.60	TOTAL MEDICAID LIAB	173,549.32
		LESS: COB	0.00
		LESS: COPAYMENT	238.90
		REIMBURSEMENT	173,310.42

TOTAL NUMBER OF CLAIMS 33

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,319.86	5,038.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79,613.00	5,074.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,449.40	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	36,544.41	0.00
EKG/ECG	10,292.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,658.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,563,105.50	68,036.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	247.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,251.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,400.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	593,512.90	46,808.28
RADIOLOGY THERAPEUTIC	38,894.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	75.60
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,515,181.00	3,700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	146,111.40	40,595.50			
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	904.32	0.00			

TOTAL ANCILLARY	4,084,895.62	169,327.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,084,895.62	169,327.60

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER
501 REDMOND RD
ROME,GA 30165-1415

PROVIDER NUMBER
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,581,155.56	ADJUSTMENTS	168,757.16
COVERED CHARGES	15,929,884.84	CONTRACTUAL ALLOW	11,841,822.77
NON-COVERD CHARGES	651,270.72	TOTAL MEDICAID LIAB	4,088,062.07
		LESS: COB	89,445.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,998,616.93

TOTAL NUMBER OF ADMISSIONS 499

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,782	0	1,237,100.00	356,134.00
ROUTINE NURSERY	462	0	1,331,906.00	78,157.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,244	0	2,569,006.00	434,291.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	243	0	438,884.00	0.00
NICU	73	0	493,245.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	316	0	932,129.00	0.00
TOTAL ACCOMODATIONS	2,560	0	3,501,135.00	434,291.00

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	890,957.87	0.00	OTHER LAB	105,433.00	0.00
MED/SURG SUPPLY	556,966.81	188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,626,597.87	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,053,048.00	3,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	84,355.51	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	194,492.00	0.00	MRI SERVICES	189,083.00	0.00
IV THERAPY	229,458.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	596,736.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	379,704.00	11,951.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	594,135.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	257,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	208,360.00	1,278.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	636,191.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	143,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	24,808.72
LABORATORY PATHOLOGIC	128,058.00	0.00	INJECTABLE DRUGS	916,309.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,209.15	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	35,862.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	174,265.00	11,508.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,249.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	159,310.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	50,554.00
OTHER IMAGING SERVICE	160,875.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	224,261.00	100,338.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,868.00	13,000.00			
AUDIOLOGY	14,393.00	0.00			
CARDIOLOGY	440,697.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,913.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	97,912.00	0.00			

TOTAL ANCILLARY	12,428,749.84	216,979.72
TOTAL ACCOMODATIONS	3,501,135.00	434,291.00
TOTAL CHARGES	15,929,884.84	651,270.72

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 10/01/17 THROUGH 06/30/18
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	2018051112046	10/24/17 - 10/27/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018051113088	10/15/17 - 10/19/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018051113100	10/20/17 - 10/21/17	02/26/18	0.00	5,505.00	0.00	0.00	0.00
615	2018052000349	02/13/18 - 02/14/18	02/26/18	0.00	2,895.00	0.00	0.00	0.00
615	2018051112533	02/07/18 - 02/11/18	02/26/18	0.00	5,726.00	0.00	0.00	0.00
615	2018096075836	01/15/18 - 01/17/18	04/16/18	0.00	2,783.00	0.00	0.00	0.00
615	2018106030500	04/07/18 - 04/10/18	04/23/18	0.00	5,726.00	0.00	0.00	0.00
615	2018128074181	04/30/18 - 05/03/18	05/14/18	0.00	5,726.00	0.00	0.00	0.00
615	2018136072486	01/21/18 - 01/23/18	05/21/18	0.00	5,505.00	0.00	0.00	0.00
615	2018190025030	06/22/18 - 06/28/18	07/16/18	0.00	2,895.00	0.00	0.00	0.00
615	2318205000410	10/17/17 - 10/19/17	08/20/18	0.00	2,783.00	0.00	717.36	0.00
TOTAL				0.00	50,554.00	0.00	717.36	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,118,620.86	ADJUSTMENTS	185,542.11
COVERED CHARGES	8,967,219.67	CONTRACTUAL ALLOW	7,987,593.57
NON-COVERD CHARGES	1,151,401.19	TOTAL MEDICAID LIAB	979,626.10
		LESS: COB	2,564.40
		LESS: COPAYMENT	2,017.75
		REIMBURSEMENT	975,043.95
		ALL OTHER	855,781.71
		FEE SCHEDULE-LAB	110,750.36
		INJECTABLE DRUGS	8,511.88

TOTAL NUMBER OF CLAIMS 2,662

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,168.72	2,720.09	OTHER LAB	81,344.00	0.00
MED/SURG SUPPLY	170,002.41	19,305.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	247,472.00	69,907.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,485,547.00	268,009.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,218.00	6,779.00	FEE SCHEDULE LAB	2,353,096.79	203,107.80
EKG/ECG	237,828.00	764.00	MRI SERVICES	180,640.00	24,140.00
IV THERAPY	382,801.00	38,175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	287,330.72	107,065.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,035.00	12,421.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	226,349.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	179,766.61	79,170.39	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,961,888.00	21,042.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,440.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,894.92	9,727.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,817.00	832.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,346.00	3,556.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,407.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,928.00	12,497.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,986.50	12,754.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,414.00
OTHER IMAGING SERVICE	352,253.00	84,688.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,805.00	12,890.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,214.00	75,980.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	117,095.00	45,291.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	223,953.00	759.00			

TOTAL ANCILLARY	8,967,219.67	1,151,401.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,967,219.67	1,151,401.19

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 10/01/17 THROUGH 06/30/18
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	2018051113693	01/24/18 - 01/24/18	02/26/18	0.00	2,783.00	0.00	0.00	0.00
615	2018066002572	02/10/18 - 02/10/18	03/12/18	0.00	2,895.00	0.00	0.00	0.00
615	5918095000048	10/31/17 - 10/31/17	04/09/18	0.00	2,783.00	0.00	0.00	0.00
615	5918095000048	10/31/17 - 10/31/17	04/09/18	0.00	2,722.00	0.00	0.00	0.00
615	5918128001838	12/04/17 - 12/04/17	05/14/18	0.00	2,783.00	0.00	0.00	0.00
615	5918128001838	12/04/17 - 12/04/17	05/14/18	0.00	2,722.00	0.00	0.00	0.00
615	5918310003004	06/12/18 - 06/12/18	11/12/18	0.00	2,895.00	0.00	0.00	0.00
615	5918310003004	06/12/18 - 06/12/18	11/12/18	0.00	2,831.00	0.00	0.00	0.00
TOTAL				0.00	22,414.00	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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	158,900.17	ADJUSTMENTS	0.00
COVERED CHARGES	125,353.61	CONTRACTUAL ALLOW	91,486.30
NON-COVERD CHARGES	33,546.56	TOTAL MEDICAID LIAB	33,867.31
		LESS: COB	33,849.31
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,268.85	265.14	OTHER LAB	2,728.00	0.00
MED/SURG SUPPLY	786.00	262.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,617.00	1,730.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,469.00	18,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,771.00	254.00	FEE SCHEDULE LAB	41,342.00	1,771.00
EKG/ECG	2,786.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,064.00	1,087.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,417.00	3,264.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	205.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,291.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,332.50	2,332.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,025.00	401.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,871.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,172.26	334.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	452.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	843.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,756.00	2,710.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	125,353.61	33,546.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	125,353.61	33,546.56

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	338,919.58	ADJUSTMENTS	432.52
COVERED CHARGES	315,635.58	CONTRACTUAL ALLOW	303,384.72
NON-COVERD CHARGES	23,284.00	TOTAL MEDICAID LIAB	12,250.86
		LESS: COB	0.00
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	11,878.86
		TOTAL NUMBER OF CLAIMS	219

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	4,409.00	0.00
MED/SURG SUPPLY	30.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,368.00	5,318.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,014.00	7,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,843.00	FEE SCHEDULE LAB	102,570.40	4,463.00
EKG/ECG	6,654.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,872.00	1,417.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,208.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,886.00	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	1,489.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,431.00	1,586.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,704.00	0.00			

TOTAL ANCILLARY	315,635.58	23,284.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	315,635.58	23,284.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	20,965.19	ADJUSTMENTS	0.00
COVERED CHARGES	14,086.19	CONTRACTUAL ALLOW	4,241.64
NON-COVERD CHARGES	6,879.00	TOTAL MEDICAID LIAB	9,844.55
		LESS: COB	9,838.55
		LESS: COPAYMENT	6.00
		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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	436.00	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	6,692.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,396.00	187.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	387.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	6,160.00	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	707.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	14,086.19	6,879.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,086.19	6,879.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	183,351.35	ADJUSTMENTS	11,087.46
COVERED CHARGES	137,585.68	CONTRACTUAL ALLOW	120,949.99
NON-COVERD CHARGES	45,765.67	TOTAL MEDICAID LIAB	16,635.69
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	16,623.69

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 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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	345.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,902.25	6,803.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,710.00	2,687.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,095.00	0.00
EKG/ECG	796.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	312.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,413.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	214.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,051.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,855.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,710.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,656.43	1,370.75
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	24,372.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,559.00	34,559.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,704.00	0.00			

TOTAL ANCILLARY	137,585.68	45,765.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,585.68	45,765.67

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

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 10/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	245,817.86	ADJUSTMENTS	10,887.54
COVERED CHARGES	168,395.86	CONTRACTUAL ALLOW	103,091.62
NON-COVERD CHARGES	77,422.00	TOTAL MEDICAID LIAB	65,304.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	65,304.24

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	40	0	42,578.00	77,422.00
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	40	0	42,578.00	77,422.00
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	40	0	42,578.00	77,422.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,747.60	0.00	OTHER LAB	533.55	0.00
MED/SURG SUPPLY	909.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,358.92	0.00	EDUCATION & TRAINING	143.16	0.00
RADIOLOGY-DIAGNOSTIC	2,058.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,590.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	447.78	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,586.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,172.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,438.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,202.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,681.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,223.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	505.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,218.08	0.00			

TOTAL ANCILLARY	125,817.86	0.00
TOTAL ACCOMODATIONS	42,578.00	77,422.00
TOTAL CHARGES	168,395.86	77,422.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,716,771.61	ADJUSTMENTS	73,223.57
COVERED CHARGES	1,597,908.22	CONTRACTUAL ALLOW	1,173,471.42
NON-COVERD CHARGES	118,863.39	TOTAL MEDICAID LIAB	424,436.80
		LESS: COB	3,333.41
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	420,497.39
		ALL OTHER	262,049.07
		FEE SCHEDULE-LAB	158,288.22
		INJECTABLE DRUGS	160.10

TOTAL NUMBER OF CLAIMS 1,792

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,921.68	83.00	OTHER LAB	6,705.20	0.00
MED/SURG SUPPLY	3,222.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	190.88
RADIOLOGY-DIAGNOSTIC	46,119.77	1,111.57	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,033.40	12,817.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,816.04	18,164.53	FEE SCHEDULE LAB	894,771.19	13,152.68
EKG/ECG	23,014.85	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	40,400.45	7,738.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	168,722.36	49,934.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,493.39	1,198.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	196,693.42	6,100.61	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	459.75	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	2,132.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,270.25	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	288.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,131.92	4,910.35			

TOTAL ANCILLARY	1,597,908.22	115,863.39
TOTAL ACCOMODATIONS	0.00	3,000.00
TOTAL CHARGES	1,597,908.22	118,863.39

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	657.52	ADJUSTMENTS	0.00
COVERED CHARGES	645.52	CONTRACTUAL ALLOW	303.61
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	341.91
		LESS: COB	341.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	149.70	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	274.72	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	221.10	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	645.52	12.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	645.52	12.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,857.96	ADJUSTMENTS	1,918.00
COVERED CHARGES	35,674.40	CONTRACTUAL ALLOW	31,294.40
NON-COVERD CHARGES	183.56	TOTAL MEDICAID LIAB	4,380.00
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	4,281.00
		TOTAL NUMBER OF CLAIMS	72

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,707.38	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	1,773.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,074.15	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,224.24	183.56
EKG/ECG	689.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,563.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	384.57	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,238.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,674.40	183.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,674.40	183.56

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	115,763.45	ADJUSTMENTS	4,856.89
COVERED CHARGES	112,476.48	CONTRACTUAL ALLOW	93,024.92
NON-COVERD CHARGES	3,286.97	TOTAL MEDICAID LIAB	19,451.56
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	19,436.56

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,386.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	353.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
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	576.28	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	101,109.30	2,990.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	517.73	236.50	FREE STANDING CLINIC	0.00	0.00
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	6,533.24	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,476.48	3,286.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	112,476.48	3,286.97

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,370,170.42	ADJUSTMENTS	1,016,455.43
COVERED CHARGES	50,601,075.23	CONTRACTUAL ALLOW	43,673,717.19
NON-COVERD CHARGES	1,769,095.19	TOTAL MEDICAID LIAB	6,927,358.04
		LESS: COB	81,400.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,845,958.00

TOTAL NUMBER OF ADMISSIONS 684

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,140	0	3,559,559.00	436,054.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,140	0	3,559,559.00	436,054.80
SPECIAL CARE SERVICES				
CCU	643	0	1,732,574.00	0.00
ICU	2,662	0	8,580,930.60	375,706.40
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,305	0	10,313,504.60	375,706.40
TOTAL ACCOMODATIONS	5,445	0	13,873,063.60	811,761.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,763,584.73	248,433.15	OTHER LAB	155,925.63	0.00
MED/SURG SUPPLY	2,144,672.94	27,343.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,497,827.27	114,448.69	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	700,064.84	11,234.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,033,599.93	79,252.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	213,599.06	338.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	312,632.53	1,536.00	MRI SERVICES	628,645.15	0.00
IV THERAPY	191,716.00	1,786.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,431,248.48	3,437.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,859,093.34	284,754.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	463,023.02	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,551.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,090,364.90	9,127.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,846.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,754.00
LABORATORY PATHOLOGIC	124,832.09	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,459.12	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	93,922.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	774,057.96	1,384.92	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,633.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	206,966.91	0.00	IMPL DEV CHARGE PATIENTS	302,761.98	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	230,911.49	1,469.83			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	217,239.74	165,178.66			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	757,040.32	735.30			
AUDIOLOGY	524.88	0.00			
CARDIOLOGY	1,144,169.21	1,910.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,353.90	209.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,741.94	0.00			

TOTAL ANCILLARY	36,728,011.63	957,333.99
TOTAL ACCOMODATIONS	13,873,063.60	811,761.20
TOTAL CHARGES	50,601,075.23	1,769,095.19

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,757,276.33	ADJUSTMENTS	268,741.62
COVERED CHARGES	23,572,145.64	CONTRACTUAL ALLOW	21,486,361.14
NON-COVERD CHARGES	1,185,130.69	TOTAL MEDICAID LIAB	2,085,784.50
		LESS: COB	478.94
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	2,083,625.56
		ALL OTHER	1,904,034.26
		FEE SCHEDULE-LAB	158,210.13
		INJECTABLE DRUGS	21,381.17

TOTAL NUMBER OF CLAIMS 5,340

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	885,957.23	0.00	OTHER LAB	246,176.24	1,990.00
MED/SURG SUPPLY	518,483.48	391.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,420,268.93	75,388.42	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,224,233.58	309,064.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,248.09	FEE SCHEDULE LAB	3,594,297.24	40,640.87
EKG/ECG	470,538.08	2,866.35	MRI SERVICES	300,515.30	26,018.95
IV THERAPY	1,425,046.73	65,710.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	963,162.44	103,412.71	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,726.67	20,519.88	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	581,656.42	0.00	AMBULANCE	0.00	0.00
GI SERVICES	76,014.27	18,369.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,353,571.53	11,987.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,512.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,373.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	927,677.15	165,311.65
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	814.34	1,383.62	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,360.92	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	888.00	7,414.24	TRAUMA RESPONSE	0.00	22,209.53
PSYCHIATRIC SERVICES	173,436.44	15,320.00	IMPL DEV CHARGE PATIENTS	33,925.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	617,045.20	178,373.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,167.80	15,228.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	260,215.97	28,023.73			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	132,177.82	58,524.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,364.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,272.87	0.00			

TOTAL ANCILLARY	23,572,145.64	1,185,130.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,572,145.64	1,185,130.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	46,207.91	ADJUSTMENTS	0.00
COVERED CHARGES	36,756.07	CONTRACTUAL ALLOW	13,547.13
NON-COVERD CHARGES	9,451.84	TOTAL MEDICAID LIAB	23,208.94
		LESS: COB	23,208.94
		LESS: COPAYMENT	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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309.00	0.00	OTHER LAB	5,970.00	0.00
MED/SURG SUPPLY	271.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,156.68	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,999.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,485.25	688.84
EKG/ECG	1,024.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,658.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,656.54	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,068.00	2,764.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	36,756.07	9,451.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,756.07	9,451.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,252,489.97	ADJUSTMENTS	326.64
COVERED CHARGES	1,220,834.20	CONTRACTUAL ALLOW	1,188,892.46
NON-COVERD CHARGES	31,655.77	TOTAL MEDICAID LIAB	31,941.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	30,864.74
		TOTAL NUMBER OF CLAIMS	571

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,138.48	0.00	OTHER LAB	7,594.00	0.00
MED/SURG SUPPLY	3,323.42	40.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,989.30	9,052.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,207.73	3,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,683.30	2,983.68
EKG/ECG	16,174.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	78,905.50	501.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	593,560.52	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,464.87	3,661.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	98.32	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,362.45	1,532.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,480.73	9,959.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,769.76	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,220,834.20	31,655.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,220,834.20	31,655.77

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97,296.05	ADJUSTMENTS	0.00
COVERED CHARGES	95,147.99	CONTRACTUAL ALLOW	82,878.27
NON-COVERD CHARGES	2,148.06	TOTAL MEDICAID LIAB	12,269.72
		LESS: COB	0.00
		LESS: COPAYMENT	16.88
		REIMBURSEMENT	12,252.84

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,971.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,216.43	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	3,187.12	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,023.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,370.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,511.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,857.09	2,148.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,010.26	0.00			

TOTAL ANCILLARY	95,147.99	2,148.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	95,147.99	2,148.06

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	35,469,730.56	ADJUSTMENTS	2,009,314.27
COVERED CHARGES	34,606,659.93	CONTRACTUAL ALLOW	24,832,889.97
NON-COVERD CHARGES	863,070.63	TOTAL MEDICAID LIAB	9,773,769.96
		LESS: COB	94,126.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,679,643.17

TOTAL NUMBER OF ADMISSIONS 967

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,552	0	2,951,897.00	318,722.00
ROUTINE NURSERY	320	0	306,159.00	44,242.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,872	0	3,258,056.00	362,964.50
SPECIAL CARE SERVICES				
CCU	126	0	256,488.00	0.00
ICU	1,673	0	2,533,059.00	0.00
NICU	23	0	42,343.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	2,831,890.00	0.00
TOTAL ACCOMODATIONS	5,694	0	6,089,946.00	362,964.50

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,302,648.17	37,660.50	OTHER LAB	111,019.50	0.00
MED/SURG SUPPLY	1,505,910.98	25,757.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,807,826.50	22,074.00	EDUCATION & TRAINING	68,039.50	988.00
RADIOLOGY-DIAGNOSTIC	335,288.50	768.00	OTHER THERAPEUTIC SVC	0.00	720.00
CT SCAN	1,392,062.00	3,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156,421.00	2,991.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	197,288.00	0.00	MRI SERVICES	273,119.00	0.00
IV THERAPY	168,505.00	1,184.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,346,711.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	129,501.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,870,390.00	6,666.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	333,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	196,392.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	793,542.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	201,273.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	46,684.75
LABORATORY PATHOLOGIC	84,744.50	0.00	INJECTABLE DRUGS	278,972.25	0.00
RADIOLOGY THERAPEUTIC	10,325.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,068.50	10,614.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	92,529.50	717.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	438,970.50	6,718.34	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,990.50	149.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,066,932.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30,475.00
OTHER IMAGING SERVICE	229,055.50	24,716.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	248,514.50	236,733.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	64,030.00	23,961.00			
AUDIOLOGY	33,798.00	0.00			
CARDIOLOGY	1,105,828.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,310.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	574,042.00	16,821.50			

TOTAL ANCILLARY	28,516,713.93	500,106.13
TOTAL ACCOMODATIONS	6,089,946.00	362,964.50
TOTAL CHARGES	34,606,659.93	863,070.63

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 10/01/17 THROUGH 09/30/18
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	5918036000529	11/20/17 - 12/05/17	02/12/18	0.00	2,169.00	0.00	0.00	0.00
615	2218058008630	02/03/18 - 02/09/18	03/05/18	0.00	2,169.00	0.00	0.00	0.00
615	5918066000900	12/31/17 - 01/04/18	03/12/18	0.00	2,169.00	0.00	0.00	0.00
615	2018071013178	12/20/17 - 12/26/17	03/19/18	0.00	2,169.00	0.00	0.00	0.00
615	2018071013213	02/16/18 - 03/06/18	03/19/18	0.00	2,169.00	0.00	0.00	0.00
615	2018080051425	03/14/18 - 03/18/18	03/26/18	0.00	2,169.00	0.00	0.00	0.00
615	2218085001408	01/03/18 - 01/19/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	2018085013206	03/18/18 - 03/21/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	2018088057516	03/21/18 - 03/23/18	04/02/18	0.00	2,169.00	0.00	0.00	0.00
615	5918092000153	02/28/18 - 03/07/18	04/09/18	0.00	2,169.00	0.00	0.00	0.00
615	2218099001322	11/02/17 - 11/05/17	04/16/18	0.00	2,169.00	0.00	0.00	0.00
615	2218130003524	03/22/18 - 04/12/18	05/14/18	0.00	2,169.00	0.00	0.00	0.00
615	2218173015532	01/25/18 - 02/01/18	06/25/18	0.00	2,169.00	0.00	0.00	0.00
615	2018199045462	07/13/18 - 07/15/18	07/23/18	0.00	2,278.00	0.00	0.00	0.00
TOTAL				0.00	30,475.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	180,368.07	ADJUSTMENTS	0.00
COVERED CHARGES	177,103.07	CONTRACTUAL ALLOW	67,324.98
NON-COVERD CHARGES	3,265.00	TOTAL MEDICAID LIAB	109,778.09
		LESS: COB	109,778.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	19	0	16,090.00	1,371.00
ROUTINE NURSERY	9	0	7,631.00	1,894.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	28	0	23,721.00	3,265.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	4	0	7,348.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	7,348.00	0.00
TOTAL ACCOMODATIONS	32	0	31,069.00	3,265.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,980.50	0.00	OTHER LAB	1,860.00	0.00
MED/SURG SUPPLY	13,359.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,088.00	0.00	EDUCATION & TRAINING	150.00	0.00
RADIOLOGY-DIAGNOSTIC	634.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,678.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,352.00	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	17,858.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,682.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,605.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,259.00	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	2,420.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,152.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	337.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	27,788.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	963.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,868.00	0.00			

TOTAL ANCILLARY	146,034.07	0.00
TOTAL ACCOMODATIONS	31,069.00	3,265.00
TOTAL CHARGES	177,103.07	3,265.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	15,238,442.31	ADJUSTMENTS	894,792.61
COVERED CHARGES	13,089,356.84	CONTRACTUAL ALLOW	9,903,573.60
NON-COVERD CHARGES	2,149,085.47	TOTAL MEDICAID LIAB	3,185,783.24
		LESS: COB	12,357.36
		LESS: COPAYMENT	8,408.70
		REIMBURSEMENT	3,165,017.18
		ALL OTHER	2,626,021.70
		FEE SCHEDULE-LAB	325,619.65
		INJECTABLE DRUGS	213,375.83

TOTAL NUMBER OF CLAIMS 7,668

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,217,806.33	674.00	OTHER LAB	187,036.00	10,986.00
MED/SURG SUPPLY	262,404.76	833.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	393.00	4,916.00
RADIOLOGY-DIAGNOSTIC	448,887.00	56,744.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,498,810.50	577,635.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	12,753.00	FEE SCHEDULE LAB	1,853,905.75	191,538.00
EKG/ECG	242,602.00	10,441.00	MRI SERVICES	235,859.00	62,263.00
IV THERAPY	452,452.00	41,143.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	543,597.88	144,396.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100,276.50	96,511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	224,834.00	7,468.00	AMBULANCE	0.00	0.00
GI SERVICES	102,777.00	48,384.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,751,570.50	57,804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	300,138.00	0.00	DRUG-SPECIFIC/HOME IV	39,226.06	7,018.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,268,716.34	385,943.98
RADIOLOGY THERAPEUTIC	253,971.50	31,321.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,222.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	507.00	17,015.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,964.00	7,855.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,416.22	25,641.61
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,507.00
OTHER IMAGING SERVICE	638,097.50	94,891.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,980.50	42,182.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,521.00	30,316.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	232,055.00	114,122.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,306.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	852,245.00	54,558.50			

TOTAL ANCILLARY	13,089,356.84	2,149,085.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,089,356.84	2,149,085.47

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 10/01/17 THROUGH 09/30/18
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	5218083002748	01/11/18 - 01/11/18	04/16/18	0.00	2,169.00	0.00	0.00	0.00
615	5918122000284	02/12/18 - 02/12/18	05/07/18	0.00	2,169.00	0.00	0.00	0.00
615	2318128000105	02/09/18 - 02/09/18	05/28/18	0.00	2,169.00	0.00	0.00	0.00
TOTAL				0.00	6,507.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	269,361.41	ADJUSTMENTS	0.00
COVERED CHARGES	185,417.43	CONTRACTUAL ALLOW	24,975.23
NON-COVERD CHARGES	83,943.98	TOTAL MEDICAID LIAB	160,442.20
		LESS: COB	160,304.20
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 113

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,148.89	0.00	OTHER LAB	3,795.00	310.00
MED/SURG SUPPLY	7,620.04	52.47	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	718.00
RADIOLOGY-DIAGNOSTIC	1,981.00	818.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,062.00	20,462.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	524.00	FEE SCHEDULE LAB	30,692.50	3,231.00
EKG/ECG	1,710.00	0.00	MRI SERVICES	3,597.00	8,512.00
IV THERAPY	9,869.50	1,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,778.00	18,384.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,511.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,756.00	333.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,622.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,226.00	4,968.75
RADIOLOGY THERAPEUTIC	9,529.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	438.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	50.00	1,707.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,783.50	11,705.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,232.00	1,962.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,038.00	5,719.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,416.00	2,439.00			

TOTAL ANCILLARY	185,417.43	83,943.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,417.43	83,943.98

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	223,820.43	ADJUSTMENTS	2,463.36
COVERED CHARGES	207,530.93	CONTRACTUAL ALLOW	188,925.19
NON-COVERD CHARGES	16,289.50	TOTAL MEDICAID LIAB	18,605.74
		LESS: COB	47.51
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	18,177.23
		TOTAL NUMBER OF CLAIMS	323

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,220.58	0.00	OTHER LAB	2,068.00	0.00
MED/SURG SUPPLY	3,321.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,486.50	1,048.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,759.00	6,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,963.50	4,688.00
EKG/ECG	3,221.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,306.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,854.00	206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,267.00	291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,501.25	2,478.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,050.00	1,375.50			
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	513.00	0.00			

TOTAL ANCILLARY	207,530.93	16,289.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	207,530.93	16,289.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,903.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,896.25	CONTRACTUAL ALLOW	365.62
NON-COVERD CHARGES	3,007.00	TOTAL MEDICAID LIAB	6,530.63
		LESS: COB	6,527.63
		LESS: COPAYMENT	3.00
		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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,977.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,830.00	30.00
EKG/ECG	190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	198.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,233.00	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	74.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,896.25	3,007.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,896.25	3,007.00

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,060,082.82	ADJUSTMENTS	414,842.17
COVERED CHARGES	6,328,108.14	CONTRACTUAL ALLOW	5,268,685.94
NON-COVERD CHARGES	731,974.68	TOTAL MEDICAID LIAB	1,059,422.20
		LESS: COB	5,495.58
		LESS: COPAYMENT	1,668.00
		REIMBURSEMENT	1,052,258.62

TOTAL NUMBER OF CLAIMS 191

GEORGIA 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	540,031.55	0.00	OTHER LAB	7,414.00	499.00
MED/SURG SUPPLY	123,914.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	491.00
RADIOLOGY-DIAGNOSTIC	50,275.00	3,192.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,220.00	40,825.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,021.50	FEE SCHEDULE LAB	79,307.75	8,396.00
EKG/ECG	4,542.00	3,230.00	MRI SERVICES	2,809.00	11,187.00
IV THERAPY	158,232.00	5,927.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	139,277.58	158,366.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,065.00	16,134.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,610.00	1,002.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,190.00	97.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,916.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,569,885.75	149,102.60
RADIOLOGY THERAPEUTIC	374,925.00	56,402.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,740.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	849.00	3,711.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,034.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	388.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	550,480.33	142,750.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,829.00	12,597.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,172.00	5,886.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,375.00	4,121.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	394,207.00	75,556.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	554.00	554.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,026.50	20,764.00			

TOTAL ANCILLARY	6,328,108.14	731,974.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,328,108.14	731,974.68

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF 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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,573,343.88	ADJUSTMENTS	120,937.42
COVERED CHARGES	1,371,683.74	CONTRACTUAL ALLOW	1,019,440.25
NON-COVERD CHARGES	201,660.14	TOTAL MEDICAID LIAB	352,243.49
		LESS: COB	35.76
		LESS: COPAYMENT	989.04
		REIMBURSEMENT	351,218.69
		ALL OTHER	331,742.69
		FEE SCHEDULE-LAB	17,238.81
		INJECTABLE DRUGS	2,237.19

TOTAL NUMBER OF CLAIMS 626

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,930.64	0.00	OTHER LAB	6,468.00	0.00
MED/SURG SUPPLY	47,067.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,906.50	211.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,799.00	48,827.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	222.00	1,341.00	FEE SCHEDULE LAB	80,117.50	3,780.50
EKG/ECG	5,501.00	1,140.00	MRI SERVICES	28,950.00	5,994.00
IV THERAPY	0.00	102.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	326,931.03	63,608.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,061.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,049.00	65,331.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,819.00	109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,007.18	5,947.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,615.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	46,140.47	0.00
LITHOTRIPSY	64,516.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,848.00	2,002.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,184.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,288.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,753.00	651.00			

TOTAL ANCILLARY	1,371,683.74	201,660.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,371,683.74	201,660.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	41,413.99	ADJUSTMENTS	0.00
COVERED CHARGES	34,791.64	CONTRACTUAL ALLOW	12,043.86
NON-COVERD CHARGES	6,622.35	TOTAL MEDICAID LIAB	22,747.78
		LESS: COB	22,729.78
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,199.25	0.00	OTHER LAB	499.00	0.00
MED/SURG SUPPLY	1,049.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,298.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,761.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	768.00	216.00
EKG/ECG	190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,853.90	6,106.10	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	6,060.00	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	6,166.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	625.75	300.25
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	320.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	34,791.64	6,622.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	34,791.64	6,622.35

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	97.00	ADJUSTMENTS	0.00
COVERED CHARGES	97.00	CONTRACTUAL ALLOW	41.06
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	55.94
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	52.94
		TOTAL NUMBER OF CLAIMS	1

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 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	97.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	97.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	97.00	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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	188,309.24	ADJUSTMENTS	26,002.20
COVERED CHARGES	170,820.38	CONTRACTUAL ALLOW	134,404.70
NON-COVERD CHARGES	17,488.86	TOTAL MEDICAID LIAB	36,415.68
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	36,400.68

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,062.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,222.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	655.00	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	566.00	20.00
EKG/ECG	0.00	190.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,821.14	16,432.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,989.00	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	11,468.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,401.75	846.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	76,641.65	0.00
LITHOTRIPSY	35,429.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,564.00	0.00			

TOTAL ANCILLARY	170,820.38	17,488.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	170,820.38	17,488.86

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

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	17,602,646.88	ADJUSTMENTS	234,437.35
COVERED CHARGES	16,034,877.00	CONTRACTUAL ALLOW	10,035,235.52
NON-COVERD CHARGES	1,567,769.88	TOTAL MEDICAID LIAB	5,999,641.48
		LESS: COB	84,590.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,915,050.85

TOTAL NUMBER OF ADMISSIONS 797

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,102	0	2,761,692.00	1,513,410.75
ROUTINE NURSERY	118	0	71,597.50	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,220	0	2,833,289.50	1,513,410.75
SPECIAL CARE SERVICES				
CCU	26	0	38,057.50	0.00
ICU	445	0	629,558.75	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	471	0	667,616.25	0.00
TOTAL ACCOMODATIONS	4,691	0	3,500,905.75	1,513,410.75

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	956,652.05	0.00	OTHER LAB	73,012.00	0.00
MED/SURG SUPPLY	1,236,074.66	2,034.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,072,190.03	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	260,409.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	437,635.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	300,248.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	108,453.00	0.00	MRI SERVICES	125,076.75	1,148.50
IV THERAPY	95,788.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	939,812.25	6,460.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	68,901.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445,645.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	583,683.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	152,547.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	709,348.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,887.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	7,059.50
LABORATORY PATHOLOGIC	155,580.75	0.00	INJECTABLE DRUGS	2,115,855.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	160,067.19	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	30,942.73	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	116,806.50	2,163.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	785.50	2,570.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	568,719.25	0.00
LITHOTRIPSY	11,944.00	0.00	NO CC/INVALID REV CODE	0.00	3,360.00
OTHER IMAGING SERVICE	53,948.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,061.00	10,977.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,220.50	12,541.75			
AUDIOLOGY	15,528.00	0.00			
CARDIOLOGY	322,940.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,417.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	156,788.45	6,044.00			

TOTAL ANCILLARY	12,533,971.25	54,359.13
TOTAL ACCOMODATIONS	3,500,905.75	1,513,410.75
TOTAL CHARGES	16,034,877.00	1,567,769.88

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 01/01/18 THROUGH 12/31/18
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	2019022000081	12/03/18 - 12/12/18	01/28/19	0.00	1,680.00	0.00	0.00	0.00
615	2219043008830	11/18/18 - 11/21/18	02/18/19	0.00	1,680.00	0.00	0.00	0.00
TOTAL				0.00	3,360.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	94,248.34	ADJUSTMENTS	0.00
COVERED CHARGES	81,710.34	CONTRACTUAL ALLOW	28,056.77
NON-COVERD CHARGES	12,538.00	TOTAL MEDICAID LIAB	53,653.57
		LESS: COB	53,653.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	34	0	22,679.00	12,349.00
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	34	0	22,679.00	12,349.00
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	34	0	22,679.00	12,349.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,607.33	0.00	OTHER LAB	26.25	0.00
MED/SURG SUPPLY	2,543.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,226.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	535.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,440.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	290.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,014.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,025.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,447.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,322.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,171.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,378.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	404.25	0.00	INJECTABLE DRUGS	14,848.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,855.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	967.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,928.00	189.00			

TOTAL ANCILLARY	59,031.34	189.00
TOTAL ACCOMODATIONS	22,679.00	12,349.00
TOTAL CHARGES	81,710.34	12,538.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,744,096.28	ADJUSTMENTS	451,971.51
COVERED CHARGES	7,672,040.50	CONTRACTUAL ALLOW	5,769,181.09
NON-COVERD CHARGES	2,072,055.78	TOTAL MEDICAID LIAB	1,902,859.41
		LESS: COB	8,543.10
		LESS: COPAYMENT	4,837.20
		REIMBURSEMENT	1,889,479.11
		ALL OTHER	1,699,758.72
		FEE SCHEDULE-LAB	161,906.47
		INJECTABLE DRUGS	27,813.92

TOTAL NUMBER OF CLAIMS 3,771

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,764.60	3,616.34	OTHER LAB	76,691.78	703.50
MED/SURG SUPPLY	488,095.28	43,833.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	409,268.25	45,751.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	572,360.75	106,971.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152,427.00	18,564.50	FEE SCHEDULE LAB	1,140,860.83	136,993.41
EKG/ECG	151,975.00	4,205.00	MRI SERVICES	110,656.50	26,133.25
IV THERAPY	299,879.38	8,966.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	468,345.33	369,539.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	350.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,736.75	4,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	368,744.75	607.50	AMBULANCE	0.00	0.00
GI SERVICES	48,087.75	31,310.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,124,187.50	17,640.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	85,776.25	525.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	244,585.88	1,043,707.58
RADIOLOGY THERAPEUTIC	23,164.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,787.50	8,058.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,947.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,412.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,390.86	23,671.68	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	53.00	IMPL DEV CHARGE PATIENTS	58,359.00	14,722.75
LITHOTRIPSY	11,944.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	78,938.00	14,133.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,682.25	5,722.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,373.00	53,199.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	179,425.50	67,173.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,557.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,624.56	17,251.06			

TOTAL ANCILLARY	7,672,040.50	2,072,055.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,672,040.50	2,072,055.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,869.56	ADJUSTMENTS	0.00
COVERED CHARGES	82,410.59	CONTRACTUAL ALLOW	45,730.72
NON-COVERD CHARGES	38,458.97	TOTAL MEDICAID LIAB	36,679.87
		LESS: COB	36,599.43
		LESS: COPAYMENT	80.44
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	899.60	0.00	OTHER LAB	1,149.75	0.00
MED/SURG SUPPLY	5,866.75	222.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,728.25	1,723.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,242.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,965.75	1,835.00
EKG/ECG	1,885.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,649.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,173.37	9,554.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,434.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,343.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,372.50	375.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,187.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,104.51	1,254.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	446.11	297.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,877.50	0.00	IMPL DEV CHARGE PATIENTS	1,142.50	9,639.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	335.00	452.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	519.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193.25	0.00			

TOTAL ANCILLARY	82,410.59	38,458.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,410.59	38,458.97

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	219,150.68	ADJUSTMENTS	3,970.18
COVERED CHARGES	210,062.54	CONTRACTUAL ALLOW	197,822.70
NON-COVERD CHARGES	9,088.14	TOTAL MEDICAID LIAB	12,239.84
		LESS: COB	159.10
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	11,612.74
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,955.72	1.92	OTHER LAB	572.25	0.00
MED/SURG SUPPLY	4,362.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,221.25	2,885.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,156.50	2,178.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,039.25	1,539.00
EKG/ECG	3,480.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,720.50	206.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	546.00	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	131,752.00	375.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,084.32	1,481.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,073.50	357.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4.00	0.00			

TOTAL ANCILLARY	210,062.54	9,088.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	210,062.54	9,088.14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,663.67	ADJUSTMENTS	0.00
COVERED CHARGES	5,574.17	CONTRACTUAL ALLOW	4,469.73
NON-COVERD CHARGES	2,089.50	TOTAL MEDICAID LIAB	1,104.44
		LESS: COB	1,098.44
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	168.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201.50	201.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,308.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,024.00	0.00
EKG/ECG	145.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	44.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,892.75	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	95.50	127.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	452.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,574.17	2,089.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,574.17	2,089.50

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,574,207.41	ADJUSTMENTS	104,351.29
COVERED CHARGES	2,145,757.72	CONTRACTUAL ALLOW	1,865,727.28
NON-COVERD CHARGES	428,449.69	TOTAL MEDICAID LIAB	280,030.44
		LESS: COB	0.00
		LESS: COPAYMENT	190.35
		REIMBURSEMENT	279,840.09
		TOTAL NUMBER OF CLAIMS	51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,680.60	32.25	OTHER LAB	26.25	26.25
MED/SURG SUPPLY	252,223.55	24,936.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,690.25	4,769.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,390.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,002.27	FEE SCHEDULE LAB	15,729.25	2,430.50
EKG/ECG	1,595.00	145.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,702.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	815,502.37	61,285.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,012.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	211,480.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,509.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,882.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,198.95	17,761.26
RADIOLOGY THERAPEUTIC	1,966.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	879.53	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	283.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	517,169.00	199,458.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,680.00	335.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,836.50	181.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,440.25	115,206.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,758.00	0.00			

TOTAL ANCILLARY	2,145,757.72	428,449.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,145,757.72	428,449.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,935,446.26	ADJUSTMENTS	984,377.75
COVERED CHARGES	28,696,522.24	CONTRACTUAL ALLOW	21,409,579.84
NON-COVERD CHARGES	238,924.02	TOTAL MEDICAID LIAB	7,286,942.40
		LESS: COB	111,627.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,175,314.58

TOTAL NUMBER OF ADMISSIONS 458

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,416	0	1,486,800.00	48,357.00
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	1,416	0	1,486,800.00	48,357.00
SPECIAL CARE SERVICES				
CCU	267	0	914,808.00	0.00
ICU	1,721	0	3,763,270.00	4,581.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,988	0	4,678,078.00	4,581.00
TOTAL ACCOMODATIONS	3,404	0	6,164,878.00	52,938.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,286,414.00	1,306.00	OTHER LAB	130,625.50	0.00
MED/SURG SUPPLY	1,033,597.00	3,520.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,917,844.68	8,365.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	721,576.00	436.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,043,447.00	51,395.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	324,392.02	248.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	88,842.00	0.00	MRI SERVICES	319,791.00	0.00
IV THERAPY	381,580.00	1,613.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,838,368.00	10,799.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,673,070.00	6.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	501,804.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,902.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	676,788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	251,596.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	44,663.00	0.00	INJECTABLE DRUGS	2,967,717.00	452.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	116,475.93	0.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	152,110.11	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	276,247.00	7,047.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	2,102,681.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,700.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	412,524.00	10,069.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,649.00	90,730.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	770,061.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,709.00	0.00			

TOTAL ANCILLARY	22,531,644.24	185,986.02
TOTAL ACCOMODATIONS	6,164,878.00	52,938.00
TOTAL CHARGES	28,696,522.24	238,924.02

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	209,164.03	ADJUSTMENTS	0.00
COVERED CHARGES	203,600.03	CONTRACTUAL ALLOW	141,410.83
NON-COVERD CHARGES	5,564.00	TOTAL MEDICAID LIAB	62,189.20
		LESS: COB	62,189.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	13,650.00	416.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	13,650.00	416.00
SPECIAL CARE SERVICES				
CCU	2	0	7,060.00	0.00
ICU	19	0	26,866.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	33,926.00	0.00
TOTAL ACCOMODATIONS	34	0	47,576.00	416.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,908.00	0.00	OTHER LAB	2,211.00	0.00
MED/SURG SUPPLY	4,562.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,532.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,903.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,588.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,288.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,061.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,201.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,317.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,651.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	727.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,399.00	4,698.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	7,016.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	436.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	730.00	450.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,701.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	156,024.03	5,148.00
TOTAL ACCOMODATIONS	47,576.00	416.00
TOTAL CHARGES	203,600.03	5,564.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,199,401.42	ADJUSTMENTS	241,549.55
COVERED CHARGES	8,245,104.12	CONTRACTUAL ALLOW	7,029,140.19
NON-COVERD CHARGES	954,297.30	TOTAL MEDICAID LIAB	1,215,963.93
		LESS: COB	2,240.73
		LESS: COPAYMENT	2,463.00
		REIMBURSEMENT	1,211,260.20
		ALL OTHER	1,149,835.15
		FEE SCHEDULE-LAB	61,387.83
		INJECTABLE DRUGS	37.22

TOTAL NUMBER OF CLAIMS 2,493

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	527,172.00	952.00	OTHER LAB	83,876.00	737.00
MED/SURG SUPPLY	143,683.00	1,150.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	404,788.00	20,921.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,051,258.00	158,084.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,232.00	25,217.26	FEE SCHEDULE LAB	557,201.80	44,166.62
EKG/ECG	67,344.00	1,104.00	MRI SERVICES	256,618.00	33,785.00
IV THERAPY	723,794.00	16,608.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,714.62	221,360.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	253,863.00	7,204.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,993.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	53,952.00	19,972.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,437,832.50	11,641.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,229.00	56.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,211.00	4,979.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511.00	2,118.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,171.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	30.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	219,789.00	32,975.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	116,927.00	15,607.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,963.00	3,183.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	254,092.00	184,713.00			
AUDIOLOGY	63,940.00	41,633.00			
CARDIOLOGY	277,451.00	92,657.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,713.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,026.20	7,272.00			

TOTAL ANCILLARY	8,245,104.12	954,297.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,245,104.12	954,297.30

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	146,530.96	ADJUSTMENTS	0.00
COVERED CHARGES	110,295.96	CONTRACTUAL ALLOW	76,888.56
NON-COVERD CHARGES	36,235.00	TOTAL MEDICAID LIAB	33,407.40
		LESS: COB	33,383.40
		LESS: COPAYMENT	24.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,947.00	53.00	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	3,363.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,473.00	2,946.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,009.00	488.00
EKG/ECG	1,288.00	0.00	MRI SERVICES	16,440.00	9,428.00
IV THERAPY	9,247.00	508.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,751.00	5,370.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,505.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,898.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,660.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,030.00	1,458.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,520.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	635.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	8,629.00			
AUDIOLOGY	2,570.00	4,015.00			
CARDIOLOGY	723.00	1,185.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,353.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,038.96	0.00			

TOTAL ANCILLARY	110,295.96	36,235.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	110,295.96	36,235.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	243,476.00	ADJUSTMENTS	588.34
COVERED CHARGES	240,128.00	CONTRACTUAL ALLOW	231,233.54
NON-COVERD CHARGES	3,348.00	TOTAL MEDICAID LIAB	8,894.46
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	8,561.46
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,887.00	0.00	OTHER LAB	3,454.00	0.00
MED/SURG SUPPLY	118.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,931.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,902.00	1,473.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,469.00	1,621.00
EKG/ECG	2,208.00	0.00	MRI SERVICES	5,288.00	0.00
IV THERAPY	30,463.00	254.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,118.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	119,352.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,912.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,026.00	0.00			

TOTAL ANCILLARY	240,128.00	3,348.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	240,128.00	3,348.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	9,813.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,393.00	CONTRACTUAL ALLOW	7,453.58
NON-COVERD CHARGES	420.00	TOTAL MEDICAID LIAB	1,939.42
		LESS: COB	1,933.42
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	2,410.00	367.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,226.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	3,364.00	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	393.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	9,393.00	420.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,393.00	420.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH
11705 MERCY BLVD
SAVANNAH,GA 31419-1711

PROVIDER NUMBER
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	421,041.02	ADJUSTMENTS	21,681.64
COVERED CHARGES	351,412.66	CONTRACTUAL ALLOW	302,265.66
NON-COVERD CHARGES	69,628.36	TOTAL MEDICAID LIAB	49,147.00
		LESS: COB	5,424.38
		LESS: COPAYMENT	33.88
		REIMBURSEMENT	43,688.74

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,870.00	229.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52,524.00	32.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,601.00	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	597.02	FEE SCHEDULE LAB	4,932.00	0.00
EKG/ECG	552.00	184.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,739.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,034.00	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	10,110.00	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	142,174.00	2,870.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	265.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,177.66	65,380.34			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	966.00	336.00			

TOTAL ANCILLARY	351,412.66	69,628.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	351,412.66	69,628.36

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,575,415.20	ADJUSTMENTS	1,755,874.83
COVERED CHARGES	28,703,450.37	CONTRACTUAL ALLOW	19,084,287.15
NON-COVERD CHARGES	1,871,964.83	TOTAL MEDICAID LIAB	9,619,163.22
		LESS: COB	254,252.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,364,910.96

TOTAL NUMBER OF ADMISSIONS 525

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,760	0	3,684,206.00	652,126.00
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	2,760	0	3,684,206.00	652,126.00
SPECIAL CARE SERVICES				
CCU	147	0	878,449.00	24,572.00
ICU	818	0	3,830,338.00	58,367.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	965	0	4,708,787.00	82,939.00
TOTAL ACCOMODATIONS	3,725	0	8,392,993.00	735,065.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,007,281.51	13,820.51	OTHER LAB	117,563.00	1,872.00
MED/SURG SUPPLY	1,132,350.67	70,315.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,771,079.00	109,363.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	493,899.64	2,698.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	941,565.00	1,439.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	193,050.45	4,034.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	90,775.00	924.00	MRI SERVICES	393,326.00	8,958.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,604,188.00	60,576.00	DURABLE MED. EQUIP.	0.00	6,017.55
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	740,892.00	5,743.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	659,147.00	10,062.00	AMBULANCE	0.00	0.00
GI SERVICES	235,903.00	1,242.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	665,979.00	3,471.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	189,844.00	1,280.00	DRUG-SPECIFIC/HOME IV	0.00	40,760.20
LABORATORY PATHOLOGIC	165,492.00	339.00	INJECTABLE DRUGS	2,336,071.76	547,223.05
RADIOLOGY THERAPEUTIC	43,543.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	143,404.12	5,314.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,236.21	2,079.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	429,110.00	5,967.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,952.00	137.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,192,011.91	4,356.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	140,629.00
OTHER IMAGING SERVICE	92,587.00	2,253.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	339,688.00	56,167.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,782.00	5,580.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,111,859.10	24,280.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,489.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,388.00	0.00			

TOTAL ANCILLARY	20,310,457.37	1,136,899.83
TOTAL ACCOMODATIONS	8,392,993.00	735,065.00
TOTAL CHARGES	28,703,450.37	1,871,964.83

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2017278048541	09/26/17 - 09/27/17	10/09/17	0.00	2,698.00	0.00	0.00	0.00
614	2017341097170	10/17/17 - 11/02/17	12/11/17	0.00	8,958.00	0.00	0.00	0.00
615	2318011000162	11/09/17 - 11/16/17	02/05/18	0.00	8,958.00	0.00	2,953.49	0.00
615	9718024981025	09/15/17 - 09/17/17	01/29/18	0.00	8,958.00	0.00	1,611.25	0.00
615	2018058045292	02/14/18 - 02/19/18	03/05/18	0.00	13,437.00	0.00	0.00	0.00
615	9818063000153	10/28/17 - 11/30/17	03/12/18	0.00	2,698.00	0.00	0.00	0.00
614	2318078000132	10/09/17 - 10/12/17	03/26/18	0.00	4,479.00	0.00	1,368.97	0.00
615	2018089056555	01/14/18 - 02/12/18	04/09/18	0.00	5,396.00	0.00	0.00	0.00
615	2018152085803	05/21/18 - 05/27/18	06/11/18	0.00	5,396.00	0.00	0.00	0.00
614	2318159000306	04/19/18 - 04/27/18	07/02/18	0.00	5,396.00	0.00	0.00	0.00
614	2318190000028	05/31/18 - 06/08/18	07/23/18	0.00	2,698.00	0.00	5,465.32	0.00
615	2018197041538	07/06/18 - 07/11/18	07/23/18	0.00	7,177.00	0.00	0.00	0.00
614	5218206000350	12/22/17 - 01/26/18	07/30/18	0.00	2,485.00	0.00	0.00	0.00
614	2318232000123	04/09/18 - 04/23/18	09/10/18	0.00	2,698.00	0.00	2,782.89	0.00
615	2018245001768	08/22/18 - 08/28/18	09/10/18	0.00	2,698.00	0.00	0.00	0.00
614	2318283000420	10/22/17 - 11/15/17	11/12/18	0.00	5,396.00	0.00	0.00	0.00
614	2318296000443	02/07/18 - 03/09/18	11/19/18	0.00	4,479.00	0.00	0.00	0.00
614	2018299079640	04/01/18 - 05/01/18	11/05/18	0.00	5,396.00	0.00	0.00	0.00
615	2318313000212	07/27/18 - 07/30/18	12/10/18	0.00	8,958.00	0.00	0.00	0.00
615	2019038106587	07/13/18 - 07/14/18	02/11/19	0.00	8,958.00	0.00	0.00	0.00
614	2319092000053	04/07/18 - 04/11/18	04/08/19	0.00	8,958.00	0.00	2,168.97	0.00
615	2219144006854	06/28/18 - 07/06/18	05/27/19	0.00	2,698.00	0.00	0.00	0.00
615	2019178079219	06/04/18 - 06/06/18	07/01/19	0.00	8,958.00	0.00	0.00	0.00
615	2219203007459	11/08/17 - 12/14/17	07/29/19	0.00	2,698.00	0.00	0.00	0.00
TOTAL				0.00	140,629.00	0.00	16,350.89	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	140,609.98	ADJUSTMENTS	0.00
COVERED CHARGES	139,083.98	CONTRACTUAL ALLOW	44,237.86
NON-COVERD CHARGES	1,526.00	TOTAL MEDICAID LIAB	94,846.12
		LESS: COB	94,846.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	14	0	20,454.00	1,526.00
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	20,454.00	1,526.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	6,143.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,143.00	0.00
TOTAL ACCOMODATIONS	15	0	26,597.00	1,526.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,458.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,801.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,232.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,011.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,086.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	154.00	0.00	MRI SERVICES	13,437.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,210.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,243.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,373.00	0.00	INJECTABLE DRUGS	3,891.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,290.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	8,157.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	383.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,486.98	0.00
TOTAL ACCOMODATIONS	26,597.00	1,526.00
TOTAL CHARGES	139,083.98	1,526.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,259,930.22	ADJUSTMENTS	136,591.71
COVERED CHARGES	4,479,762.72	CONTRACTUAL ALLOW	3,650,013.18
NON-COVERD CHARGES	1,780,167.50	TOTAL MEDICAID LIAB	829,749.54
		LESS: COB	314.12
		LESS: COPAYMENT	2,715.33
		REIMBURSEMENT	826,720.09
		ALL OTHER	755,332.61
		FEE SCHEDULE-LAB	59,009.61
		INJECTABLE DRUGS	12,377.87

TOTAL NUMBER OF CLAIMS 1,593

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,055.00	51,331.51	OTHER LAB	76,282.00	0.00
MED/SURG SUPPLY	115,483.00	49.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141,716.00	84,142.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	480,614.00	303,165.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,661.00	FEE SCHEDULE LAB	538,246.00	44,129.00
EKG/ECG	44,609.00	2,156.00	MRI SERVICES	244,617.00	221,305.00
IV THERAPY	2,450.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	522,983.00	147,254.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,741.00	3,519.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,204.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	144,061.00	74,291.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	755,325.00	10,261.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93,712.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	196,422.57	70,067.81
RADIOLOGY THERAPEUTIC	136,898.00	232,125.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,998.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,760.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	37,791.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,759.00	415.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,780.00	73,634.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	57,363.00
OTHER IMAGING SERVICE	240,675.00	96,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,492.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,328.00	115,333.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	319,806.15	142,456.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,547.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,957.00	2,527.00			

TOTAL ANCILLARY	4,479,762.72	1,780,167.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,479,762.72	1,780,167.50

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
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2017283097273	10/02/17 - 10/02/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017283097273	10/02/17 - 10/02/17	10/16/17	0.00	2,698.00	0.00	0.00	0.00
615	2017360065275	12/15/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	2017360065275	12/15/17 - 12/15/17	01/01/18	0.00	4,479.00	0.00	0.00	0.00
615	2018114002905	04/14/18 - 04/14/18	04/30/18	0.00	2,698.00	0.00	0.00	0.00
615	2018114002905	04/14/18 - 04/14/18	04/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018122080318	04/25/18 - 04/25/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018122080318	04/25/18 - 04/25/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2218207001996	06/17/18 - 06/17/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2218207001996	06/17/18 - 06/17/18	07/30/18	0.00	4,479.00	0.00	0.00	0.00
615	2018212069901	07/17/18 - 07/17/18	08/06/18	0.00	4,479.00	0.00	0.00	0.00
615	2018212069901	07/17/18 - 07/17/18	08/06/18	0.00	4,479.00	0.00	0.00	0.00
615	2018254077235	08/28/18 - 08/28/18	09/17/18	0.00	4,479.00	0.00	0.00	0.00
615	2018254077235	08/28/18 - 08/28/18	09/17/18	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	57,363.00	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	240,532.12	ADJUSTMENTS	0.00
COVERED CHARGES	123,344.79	CONTRACTUAL ALLOW	43,897.19
NON-COVERD CHARGES	117,187.33	TOTAL MEDICAID LIAB	79,447.60
		LESS: COB	79,349.88
		LESS: COPAYMENT	97.72
		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

SAINT JOSEPH'S HOSPITAL OF ATLANTA
5665 PEACHTREE DUNWOODY RD NE
ATLANTA,GA 30342-1701

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,645.78	6,806.09	OTHER LAB	2,808.00	0.00
MED/SURG SUPPLY	7,553.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,559.00	3,474.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,471.00	22,492.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,579.00	1,954.00
EKG/ECG	616.00	308.00	MRI SERVICES	0.00	40,311.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,695.00	17,290.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	354.00	177.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,628.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,875.00	475.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,649.01	1,503.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,989.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	108.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,315.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,528.00	1,010.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,667.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,382.00	12,308.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,474.00	0.00			

TOTAL ANCILLARY	123,344.79	117,187.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,344.79	117,187.33

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,553.39	ADJUSTMENTS	192.39
COVERED CHARGES	25,485.08	CONTRACTUAL ALLOW	23,885.19
NON-COVERD CHARGES	8,068.31	TOTAL MEDICAID LIAB	1,599.89
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	1,518.89
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	588.00	372.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,276.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,150.00	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	19,651.00	258.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,385.08	162.31
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	587.00	0.00			

TOTAL ANCILLARY	25,485.08	8,068.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,485.08	8,068.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,964.33	ADJUSTMENTS	0.00
COVERED CHARGES	2,894.33	CONTRACTUAL ALLOW	1,766.31
NON-COVERD CHARGES	70.00	TOTAL MEDICAID LIAB	1,128.02
		LESS: COB	1,128.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.33	70.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8.00	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	1,228.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	312.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,337.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,894.33	70.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,894.33	70.00

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	413,682.43	ADJUSTMENTS	17,499.69
COVERED CHARGES	310,599.72	CONTRACTUAL ALLOW	263,885.88
NON-COVERD CHARGES	103,082.71	TOTAL MEDICAID LIAB	46,713.84
		LESS: COB	0.00
		LESS: COPAYMENT	41.38
		REIMBURSEMENT	46,672.46

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,486.95	2,291.08	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,557.00	64.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	534.00	21,708.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,693.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,438.00	260.00
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	93,077.00	2,947.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,399.00	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	1,100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,448.17	2,000.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,334.60	63,296.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	104.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	262.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,811.00	7,823.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	310,599.72	103,082.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	310,599.72	103,082.71

GEORGIA DEPARTMENT OF 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,491,666.73	ADJUSTMENTS	338,304.85
COVERED CHARGES	12,724,337.73	CONTRACTUAL ALLOW	8,572,532.14
NON-COVERD CHARGES	767,329.00	TOTAL MEDICAID LIAB	4,151,805.59
		LESS: COB	67,562.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,084,243.42

TOTAL NUMBER OF ADMISSIONS 427

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,163	0	1,343,396.00	68,952.00
ROUTINE NURSERY	229	0	251,386.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,392	0	1,594,782.00	68,952.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	850	0	1,900,580.00	0.00
NICU	3	0	7,296.00	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	853	0	1,907,876.00	0.00
TOTAL ACCOMODATIONS	2,245	0	3,502,658.00	68,952.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,177,895.95	0.00	OTHER LAB	116,089.00	0.00
MED/SURG SUPPLY	475,574.16	6,263.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	742,581.86	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	281,293.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	534,493.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,149.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	131,733.00	0.00	MRI SERVICES	176,227.00	0.00
IV THERAPY	220,549.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,282,982.00	24,707.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	105,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	853,380.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	337,174.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	56,158.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	610,986.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	220,365.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	37,253.00	0.00	INJECTABLE DRUGS	1,645.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	51,117.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	41,715.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	116,223.00	2,039.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	958.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,498.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	115,575.00
OTHER IMAGING SERVICE	87,090.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	94,208.00	7,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,570.00	6,614.00			
AUDIOLOGY	685.00	0.00			
CARDIOLOGY	497,259.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,460.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,448.00	0.00			

TOTAL ANCILLARY	9,221,679.73	698,377.00
TOTAL ACCOMODATIONS	3,502,658.00	68,952.00
TOTAL CHARGES	12,724,337.73	767,329.00

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 07/01/17 THROUGH 06/30/18
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	2017221096221	07/12/17 - 07/16/17	08/14/17	0.00	2,458.00	0.00	0.00	0.00
615	2017221096259	07/18/17 - 07/20/17	08/14/17	0.00	2,221.00	0.00	0.00	0.00
614	2017258066958	08/25/17 - 08/30/17	09/25/17	0.00	872.00	0.00	0.00	0.00
615	2017258066958	08/25/17 - 08/30/17	09/25/17	0.00	2,221.00	0.00	0.00	0.00
614	5917275000920	09/14/17 - 09/20/17	10/09/17	0.00	2,998.00	0.00	0.00	0.00
615	2317285000173	09/02/17 - 09/05/17	11/20/17	0.00	4,430.00	0.00	2,222.29	0.00
615	2317293000148	07/29/17 - 08/11/17	12/04/17	0.00	2,221.00	0.00	2,704.33	0.00
614	5917297000411	09/06/17 - 09/11/17	10/30/17	0.00	4,602.00	0.00	0.00	0.00
615	5917306000105	10/05/17 - 10/26/17	11/06/17	0.00	2,221.00	0.00	0.00	0.00
618	5917306000105	10/05/17 - 10/26/17	11/06/17	0.00	2,677.00	0.00	0.00	0.00
614	2017324043529	10/24/17 - 11/03/17	11/27/17	0.00	2,458.00	0.00	0.00	0.00
615	2217332002170	10/31/17 - 11/02/17	12/04/17	0.00	2,221.00	0.00	0.00	0.00
615	2017340079555	11/19/17 - 11/24/17	12/11/17	0.00	2,221.00	0.00	0.00	0.00
614	2017342064809	11/14/17 - 11/15/17	12/18/17	0.00	2,458.00	0.00	0.00	0.00
614	2017346070984	08/01/17 - 08/04/17	12/18/17	0.00	2,458.00	0.00	0.00	0.00
614	2017364001361	11/27/17 - 12/01/17	01/08/18	0.00	1,287.00	0.00	0.00	0.00
614	2017364003930	12/04/17 - 12/13/17	01/08/18	0.00	1,287.00	0.00	0.00	0.00
615	2018009067746	12/15/17 - 12/31/17	01/15/18	0.00	2,221.00	0.00	0.00	0.00
615	2018015020400	12/16/17 - 12/20/17	01/22/18	0.00	2,221.00	0.00	0.00	0.00
615	9718052981003	11/25/17 - 01/02/18	02/26/18	0.00	4,442.00	0.00	0.00	0.00
615	2318059000083	01/12/18 - 01/15/18	03/19/18	0.00	2,221.00	0.00	2,015.14	0.00
615	2218080002972	11/17/17 - 11/24/17	03/26/18	0.00	2,221.00	0.00	0.00	0.00
614	2218080003151	01/18/18 - 01/19/18	03/26/18	0.00	2,455.00	0.00	0.00	0.00
615	2018092036680	03/01/18 - 03/03/18	04/09/18	0.00	2,221.00	0.00	0.00	0.00
614	2018092036800	03/14/18 - 03/16/18	04/09/18	0.00	2,669.00	0.00	0.00	0.00
614	2018101094248	03/18/18 - 03/21/18	04/16/18	0.00	2,455.00	0.00	0.00	0.00
614	2018101094261	03/17/18 - 03/20/18	04/16/18	0.00	3,840.00	0.00	0.00	0.00
615	2018101094267	03/16/18 - 03/17/18	04/16/18	0.00	4,430.00	0.00	0.00	0.00
615	2318116000274	03/20/18 - 03/22/18	05/07/18	0.00	2,221.00	0.00	1,704.72	0.00
614	2018122084714	04/12/18 - 04/14/18	05/07/18	0.00	2,458.00	0.00	0.00	0.00
615	2018127030146	04/10/18 - 04/11/18	05/14/18	0.00	2,221.00	0.00	0.00	0.00
615	2018128074341	04/18/18 - 04/21/18	05/14/18	0.00	2,221.00	0.00	0.00	0.00
615	2018130109742	09/15/17 - 09/17/17	05/14/18	0.00	2,221.00	0.00	0.00	0.00
614	2018143067361	05/05/18 - 05/17/18	05/28/18	0.00	2,669.00	0.00	0.00	0.00
614	2218162004123	03/08/18 - 03/21/18	06/25/18	0.00	5,151.00	0.00	0.00	0.00
614	2018185036789	06/12/18 - 06/20/18	07/09/18	0.00	2,998.00	0.00	0.00	0.00
614	2018185036908	06/13/18 - 06/17/18	07/09/18	0.00	2,669.00	0.00	0.00	0.00
614	2018192077845	05/14/18 - 05/22/18	07/16/18	0.00	4,602.00	0.00	0.00	0.00
615	2218198000182	05/08/18 - 05/24/18	07/23/18	0.00	2,221.00	0.00	0.00	0.00
614	5918200000503	04/20/18 - 04/25/18	07/23/18	0.00	1,458.00	0.00	0.00	0.00
614	2218204006167	06/25/18 - 07/03/18	07/30/18	0.00	2,669.00	0.00	0.00	0.00
614	5918213000781	06/13/18 - 06/22/18	08/06/18	0.00	3,410.00	0.00	0.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2018227087514	06/12/18 - 06/15/18	08/20/18	0.00	1,458.00	0.00	0.00	0.00
615	2019189033534	06/30/18 - 07/03/18	07/15/19	0.00	2,221.00	0.00	0.00	0.00
TOTAL				0.00	115,575.00	0.00	8,646.48	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	217,085.51	ADJUSTMENTS	0.00
COVERED CHARGES	210,456.01	CONTRACTUAL ALLOW	115,959.41
NON-COVERD CHARGES	6,629.50	TOTAL MEDICAID LIAB	94,496.60
		LESS: COB	94,496.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	36	0	41,688.00	2,088.00
ROUTINE NURSERY	5	0	9,096.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	41	0	50,784.00	2,088.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	7	0	16,662.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	16,662.00	0.00
TOTAL ACCOMODATIONS	48	0	67,446.00	2,088.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,511.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,018.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,516.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,094.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,372.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,766.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,796.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,248.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,368.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,520.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,263.00	0.00	INJECTABLE DRUGS	20,191.17	169.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,641.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,795.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	143,010.01	4,541.50
TOTAL ACCOMODATIONS	67,446.00	2,088.00
TOTAL CHARGES	210,456.01	6,629.50

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,852,629.13	ADJUSTMENTS	252,142.55
COVERED CHARGES	11,444,255.46	CONTRACTUAL ALLOW	9,086,680.79
NON-COVERD CHARGES	1,408,373.67	TOTAL MEDICAID LIAB	2,357,574.67
		LESS: COB	5,681.20
		LESS: COPAYMENT	4,693.76
		REIMBURSEMENT	2,347,199.71
		ALL OTHER	1,970,307.27
		FEE SCHEDULE-LAB	187,603.32
		INJECTABLE DRUGS	189,289.12

TOTAL NUMBER OF CLAIMS 4,927

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,313.36	4.40	OTHER LAB	108,592.00	1,830.00
MED/SURG SUPPLY	212,607.75	115,167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,848.00	522.00
RADIOLOGY-DIAGNOSTIC	594,785.00	22,339.00	OTHER THERAPEUTIC SVC	0.00	835.00
CT SCAN	1,091,958.00	105,156.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,907.00	18,663.00	FEE SCHEDULE LAB	864,179.17	42,704.64
EKG/ECG	203,475.00	16,820.00	MRI SERVICES	479,734.00	54,345.00
IV THERAPY	709,570.00	90,009.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,286,746.95	188,808.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,752.00	25,741.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	445,986.00	23,478.00	AMBULANCE	0.00	0.00
GI SERVICES	200,942.00	32,232.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,249,920.00	15,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	465,502.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	839,963.62	211,308.08
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	189.00	8,904.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,985.00	1,490.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,974.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	119,599.00	8,952.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,996.00	180,441.00
LITHOTRIPSY	15,623.00	0.00	NO CC/INVALID REV CODE	0.00	8,884.00
OTHER IMAGING SERVICE	258,336.00	46,519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,221.00	10,304.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	177,636.00	53,453.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	438,176.00	119,199.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	187,706.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,006.61	0.00			

TOTAL ANCILLARY	11,444,255.46	1,408,373.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,444,255.46	1,408,373.67

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 07/01/17 THROUGH 06/30/18
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	2018032070791	12/15/17 - 12/15/17	02/05/18	0.00	2,221.00	0.00	0.00	0.00
615	2018061002963	01/20/18 - 01/20/18	03/05/18	0.00	2,221.00	0.00	0.00	0.00
615	5918093001173	03/16/18 - 03/16/18	04/09/18	0.00	2,221.00	0.00	0.00	0.00
615	2018131066681	04/16/18 - 04/16/18	05/21/18	0.00	2,221.00	0.00	0.00	0.00
-1	2018144098743	05/15/18 - 01/01/00	07/16/18	0.00	0.00	0.00	0.00	0.00
-1	2018144098743	05/15/18 - 01/01/00	07/16/18	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	8,884.00	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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	231,670.49	ADJUSTMENTS	0.00
COVERED CHARGES	168,404.62	CONTRACTUAL ALLOW	88,558.90
NON-COVERD CHARGES	63,265.87	TOTAL MEDICAID LIAB	79,845.72
		LESS: COB	79,783.01
		LESS: COPAYMENT	62.71
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,737.61	0.00	OTHER LAB	324.00	0.00
MED/SURG SUPPLY	3,183.00	1,178.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,483.00	924.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,503.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,022.00	882.00
EKG/ECG	3,140.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,476.00	855.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,798.00	20,555.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,686.00	301.00	AMBULANCE	0.00	0.00
GI SERVICES	1,540.00	2,298.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,041.00	639.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,885.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,370.01	954.87
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	887.00	212.00	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	NO CC/INVALID REV CODE	0.00	3,410.00
OTHER IMAGING SERVICE	7,455.00	3,840.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,270.00	1,035.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,793.00	19,679.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,946.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	168,404.62	63,265.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	168,404.62	63,265.87

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
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	2018194063168	06/29/18 - 06/29/18	07/23/18	0.00	3,410.00	0.00	1,711.82	0.00
TOTAL				0.00	3,410.00	0.00	1,711.82	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	798,671.70	ADJUSTMENTS	161.82
COVERED CHARGES	770,905.68	CONTRACTUAL ALLOW	740,474.32
NON-COVERD CHARGES	27,766.02	TOTAL MEDICAID LIAB	30,431.36
		LESS: COB	0.00
		LESS: COPAYMENT	984.00
		REIMBURSEMENT	29,447.36
		TOTAL NUMBER OF CLAIMS	544

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,452.64	0.00	OTHER LAB	915.00	0.00
MED/SURG SUPPLY	3,557.90	2,511.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,501.00	3,847.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,719.00	5,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	271.00	FEE SCHEDULE LAB	65,753.00	3,167.00
EKG/ECG	12,180.00	580.00	MRI SERVICES	8,045.00	0.00
IV THERAPY	66,599.00	3,954.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,179.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,312.00	184.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,956.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	382,800.00	966.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,989.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,745.14	901.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	106.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,310.00	3,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,043.00	2,576.00			
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	2,849.00	0.00			

TOTAL ANCILLARY	770,905.68	27,766.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	770,905.68	27,766.02

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	30,482.82	ADJUSTMENTS	0.00
COVERED CHARGES	28,197.82	CONTRACTUAL ALLOW	18,209.71
NON-COVERD CHARGES	2,285.00	TOTAL MEDICAID LIAB	9,988.11
		LESS: COB	9,961.11
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.05	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	1,869.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,619.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,292.00	371.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,969.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,523.00	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	1,703.77	38.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,511.00	588.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	681.00	1,288.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	28,197.82	2,285.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,197.82	2,285.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,632,161.22	ADJUSTMENTS	65,153.84
COVERED CHARGES	2,110,031.80	CONTRACTUAL ALLOW	1,810,798.80
NON-COVERD CHARGES	522,129.42	TOTAL MEDICAID LIAB	299,233.00
		LESS: COB	0.00
		LESS: COPAYMENT	559.09
		REIMBURSEMENT	298,673.91

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,877.15	0.00	OTHER LAB	770.00	0.00
MED/SURG SUPPLY	77,287.85	35,783.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,506.00	17,416.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	613.00	FEE SCHEDULE LAB	20,649.00	3,497.00
EKG/ECG	4,060.00	580.00	MRI SERVICES	2,998.00	0.00
IV THERAPY	41,003.00	384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	765,005.25	29,903.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,505.00	5,880.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,050.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,818.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	630,121.55	15,857.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	479.00	495.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,589.00	380,720.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,998.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,626.00	2,576.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,678.00	364.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	129,675.00	25,062.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,546.00	0.00			

TOTAL ANCILLARY	2,110,031.80	522,129.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,110,031.80	522,129.42

GEORGIA 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 07/01/17 THROUGH 06/30/18
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	2018115070934	03/14/18 - 03/14/18	04/30/18	0.00	2,998.00	0.00	0.00	0.00
TOTAL				0.00	2,998.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,824,350.86	ADJUSTMENTS	6,267.97
COVERED CHARGES	1,772,025.96	CONTRACTUAL ALLOW	1,053,670.21
NON-COVERD CHARGES	52,324.90	TOTAL MEDICAID LIAB	718,355.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	718,355.75

TOTAL NUMBER OF ADMISSIONS 84

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	264	0	174,150.00	31,775.00
ROUTINE NURSERY	6	0	3,180.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	270	0	177,330.00	31,775.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	51	0	113,100.00	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	51	0	113,100.00	0.00
TOTAL ACCOMODATIONS	321	0	290,430.00	31,775.00

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192,795.16	0.00	OTHER LAB	3,024.30	0.00
MED/SURG SUPPLY	333,815.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	129,306.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,195.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,783.60	5,860.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,744.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,388.20	0.00	MRI SERVICES	6,855.50	0.00
IV THERAPY	146,017.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,856.80	630.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,538.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	228,216.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,556.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,080.05	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,617.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,022.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,017.85	0.00	INJECTABLE DRUGS	4,684.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	776.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	19,870.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,552.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,308.50	779.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,897.85	2,058.00			
AUDIOLOGY	218.85	0.00			
CARDIOLOGY	26,488.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,251.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,569.52	11,222.00			

TOTAL ANCILLARY	1,481,595.96	20,549.90
TOTAL ACCOMODATIONS	290,430.00	31,775.00
TOTAL CHARGES	1,772,025.96	52,324.90

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,277,769.41	ADJUSTMENTS	336,757.39
COVERED CHARGES	1,998,508.48	CONTRACTUAL ALLOW	1,229,055.56
NON-COVERD CHARGES	279,260.93	TOTAL MEDICAID LIAB	769,452.92
		LESS: COB	390.04
		LESS: COPAYMENT	1,856.25
		REIMBURSEMENT	767,206.63
		ALL OTHER	719,181.84
		FEE SCHEDULE-LAB	45,433.38
		INJECTABLE DRUGS	2,591.41
		TOTAL NUMBER OF CLAIMS	1,717

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,682.40	31,176.37	OTHER LAB	82,117.95	0.00
MED/SURG SUPPLY	155,951.38	99.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,942.35	5,024.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	247,296.05	46,664.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,117.45	3,829.55	FEE SCHEDULE LAB	220,379.25	11,011.18
EKG/ECG	18,023.85	1,589.30	MRI SERVICES	54,376.95	3,198.25
IV THERAPY	44,828.20	11,882.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,584.50	29,256.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	346.11	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,927.75	5,078.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,585.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,040.64	10,896.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	623,810.73	17,587.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,189.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,480.03	2,310.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,635.05	3,189.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,340.30	1,606.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,742.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,799.10	4,281.75			
BLOOD	494.60	0.00			
BLOOD STORAGE & PRO.	8,785.10	11,201.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,682.85	20,097.73			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,104.45	1,815.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,251.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,734.14	54,012.63			

TOTAL ANCILLARY	1,998,508.48	278,550.93
TOTAL ACCOMODATIONS	0.00	710.00
TOTAL CHARGES	1,998,508.48	279,260.93

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,154.96	ADJUSTMENTS	0.00
COVERED CHARGES	21,612.36	CONTRACTUAL ALLOW	4,780.43
NON-COVERD CHARGES	4,542.60	TOTAL MEDICAID LIAB	16,831.93
		LESS: COB	16,825.93
		LESS: COPAYMENT	6.00
		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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	832.51	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,511.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.85	240.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,377.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,915.78	363.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	374.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,341.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,687.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,606.60	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,707.15	915.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,552.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	961.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,606.60	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	359.00	0.00			

TOTAL ANCILLARY	21,612.36	4,542.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,612.36	4,542.60

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	200,867.93	ADJUSTMENTS	2,426.02
COVERED CHARGES	184,594.83	CONTRACTUAL ALLOW	169,748.23
NON-COVERD CHARGES	16,273.10	TOTAL MEDICAID LIAB	14,846.60
		LESS: COB	0.00
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	14,366.60

TOTAL NUMBER OF CLAIMS 253

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 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,647.05	1,828.96	OTHER LAB	1,104.15	0.00
MED/SURG SUPPLY	5,040.23	2.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,234.00	4,071.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,961.00	7,903.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	491.10	0.00	FEE SCHEDULE LAB	18,880.43	514.50
EKG/ECG	2,281.50	456.30	MRI SERVICES	0.00	0.00
IV THERAPY	3,504.70	300.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	381.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,256.75	637.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	934.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	558.05	558.05			
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	4,307.76	0.00			

TOTAL ANCILLARY	184,594.83	16,273.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	184,594.83	16,273.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,502.37	ADJUSTMENTS	0.00
COVERED CHARGES	5,549.22	CONTRACTUAL ALLOW	2,012.61
NON-COVERD CHARGES	1,953.15	TOTAL MEDICAID LIAB	3,536.61
		LESS: COB	3,530.61
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.18	74.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	828.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	217.05	1,857.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,336.54	20.90
EKG/ECG	228.15	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	2,862.00	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	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,549.22	1,953.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,549.22	1,953.15

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	389,480.77	ADJUSTMENTS	66,455.76
COVERED CHARGES	371,552.52	CONTRACTUAL ALLOW	277,283.61
NON-COVERD CHARGES	17,928.25	TOTAL MEDICAID LIAB	94,268.91
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	94,166.91
		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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,305.48	6,071.78	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	110,479.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,041.60	1,557.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,291.95	1,857.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,035.10	206.00
EKG/ECG	0.00	228.15	MRI SERVICES	0.00	0.00
IV THERAPY	3,071.10	1,368.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,393.79	4,835.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,572.50	331.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,816.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,223.00	1,104.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,881.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	139.94	22.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,198.20	343.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,101.55	0.00			

TOTAL ANCILLARY	371,552.52	17,928.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	371,552.52	17,928.25

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,695,689.53	ADJUSTMENTS	131,840.28
COVERED CHARGES	21,666,573.07	CONTRACTUAL ALLOW	15,062,061.85
NON-COVERD CHARGES	29,116.46	TOTAL MEDICAID LIAB	6,604,511.22
		LESS: COB	42,902.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,561,608.86

TOTAL NUMBER OF ADMISSIONS 676

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,490	0	1,908,472.00	3,590.00
ROUTINE NURSERY	246	0	189,960.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,736	0	2,098,432.00	3,590.00
SPECIAL CARE SERVICES				
CCU	896	0	1,734,654.00	0.00
ICU	297	0	883,872.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,193	0	2,618,526.00	0.00
TOTAL ACCOMODATIONS	2,929	0	4,716,958.00	3,590.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,571,934.36	0.00	OTHER LAB	124,554.00	0.00
MED/SURG SUPPLY	1,009,519.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,649,450.78	0.00	EDUCATION & TRAINING	9,565.00	0.00
RADIOLOGY-DIAGNOSTIC	332,933.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	947,171.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	183,977.59	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	182,718.00	0.00	MRI SERVICES	192,462.00	0.00
IV THERAPY	399,351.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,316,388.00	1,960.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	310,178.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,080,510.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319,209.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	190,140.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	794,881.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	12,759.46
LABORATORY PATHOLOGIC	52,711.00	0.00	INJECTABLE DRUGS	1,172,739.31	0.00
RADIOLOGY THERAPEUTIC	17,663.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,285.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,111.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	61,096.00	9,660.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,237.00	237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,860.00	0.00	IMPL DEV CHARGE PATIENTS	1,024,211.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	206,155.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	204,368.00	0.00			
AUDIOLOGY	16,905.00	0.00			
CARDIOLOGY	1,184,136.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,635.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193,777.32	0.00			

TOTAL ANCILLARY	16,949,615.07	25,526.46
TOTAL ACCOMODATIONS	4,716,958.00	3,590.00
TOTAL CHARGES	21,666,573.07	29,116.46

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	679,837.57	ADJUSTMENTS	0.00
COVERED CHARGES	679,587.57	CONTRACTUAL ALLOW	211,914.76
NON-COVERD CHARGES	250.00	TOTAL MEDICAID LIAB	467,672.81
		LESS: COB	467,672.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	68	0	87,244.00	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	68	0	87,244.00	0.00
SPECIAL CARE SERVICES				
CCU	31	0	60,391.00	0.00
ICU	22	0	65,472.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	53	0	125,863.00	0.00
TOTAL ACCOMODATIONS	121	0	213,107.00	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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,405.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,845.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	78,376.00	0.00	EDUCATION & TRAINING	455.00	0.00
RADIOLOGY-DIAGNOSTIC	8,922.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,962.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,505.33	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,152.00	0.00	MRI SERVICES	4,067.00	0.00
IV THERAPY	12,190.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,084.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,785.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112,388.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,960.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,570.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	440.00	0.00	INJECTABLE DRUGS	14,366.70	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	1,825.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,508.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,631.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,333.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,994.00	250.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,770.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,577.00	0.00			

TOTAL ANCILLARY	466,480.57	250.00
TOTAL ACCOMODATIONS	213,107.00	0.00
TOTAL CHARGES	679,587.57	250.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,708,102.75	ADJUSTMENTS	717,456.69
COVERED CHARGES	17,475,878.20	CONTRACTUAL ALLOW	14,175,501.93
NON-COVERD CHARGES	1,232,224.55	TOTAL MEDICAID LIAB	3,300,376.27
		LESS: COB	3,295.91
		LESS: COPAYMENT	8,403.00
		REIMBURSEMENT	3,288,677.36
		ALL OTHER	2,923,723.42
		FEE SCHEDULE-LAB	171,554.60
		INJECTABLE DRUGS	193,399.34

TOTAL NUMBER OF CLAIMS 5,968

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	547,679.17	148.56	OTHER LAB	138,472.75	1,612.00
MED/SURG SUPPLY	157,823.62	15,806.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,585.00
RADIOLOGY-DIAGNOSTIC	730,698.00	18,204.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,235,872.00	177,593.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,375.00	8,325.00	FEE SCHEDULE LAB	1,947,416.28	52,685.00
EKG/ECG	266,746.00	8,877.00	MRI SERVICES	628,103.00	50,218.00
IV THERAPY	1,235,324.00	123,579.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,057,493.49	50,488.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,509.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	230,123.00	9,090.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	235,894.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	334,351.00	8,167.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,102,835.52	31,858.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,020,432.37	208,371.00
RADIOLOGY THERAPEUTIC	320,390.00	1,785.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,015.00	1,630.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,817.00	2,740.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,728.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	340,181.56	37,276.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	434,000.00	0.00	IMPL DEV CHARGE PATIENTS	79,872.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,860.00
OTHER IMAGING SERVICE	483,823.00	90,224.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,480.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	309,835.00	61,893.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	589,255.00	115,273.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	246,882.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	698,508.00	143,297.64			

TOTAL ANCILLARY	17,475,878.20	1,232,224.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,475,878.20	1,232,224.55

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 07/01/17 THROUGH 06/30/18
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
905	5918255000602	05/17/18 - 05/17/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	05/21/18 - 05/21/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	05/23/18 - 05/23/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	06/01/18 - 06/01/18	09/17/18	0.00	372.00	0.00	0.00	0.00
905	5918255000602	06/04/18 - 06/04/18	09/17/18	0.00	372.00	0.00	0.00	0.00
TOTAL				0.00	1,860.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	336,803.22	ADJUSTMENTS	0.00
COVERED CHARGES	237,288.08	CONTRACTUAL ALLOW	54,865.33
NON-COVERD CHARGES	99,515.14	TOTAL MEDICAID LIAB	182,422.75
		LESS: COB	182,326.75
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,098.70	666.23	OTHER LAB	2,261.00	0.00
MED/SURG SUPPLY	939.60	1,544.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,526.00	2,822.00	OTHER THERAPEUTIC SVC	0.00	231.00
CT SCAN	9,260.00	32,588.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,876.00	2,166.00
EKG/ECG	4,035.00	0.00	MRI SERVICES	11,001.00	0.00
IV THERAPY	30,125.00	635.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,398.00	12,757.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	228.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,877.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,709.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,845.00	8,417.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,528.84	215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,221.94	1,279.03
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	497.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,976.00	3,720.00	IMPL DEV CHARGE PATIENTS	0.00	3,578.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14,136.00
OTHER IMAGING SERVICE	5,969.00	2,912.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,150.00	3,693.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,547.00	7,212.00			

TOTAL ANCILLARY	237,288.08	99,515.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	237,288.08	99,515.14

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
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PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
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
905	2018108028054	01/11/18 - 01/11/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/12/18 - 01/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/15/18 - 01/15/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/19/18 - 01/19/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/22/18 - 01/22/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/26/18 - 01/26/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	01/29/18 - 01/29/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/01/18 - 02/01/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/02/18 - 02/02/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/05/18 - 02/05/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/07/18 - 02/07/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/12/18 - 02/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/14/18 - 02/14/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/16/18 - 02/16/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/19/18 - 02/19/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/21/18 - 02/21/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	02/26/18 - 02/26/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/01/18 - 03/01/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/02/18 - 03/02/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/06/18 - 03/06/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/09/18 - 03/09/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/12/18 - 03/12/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018108028054	03/16/18 - 03/16/18	04/23/18	0.00	372.00	0.00	6,271.84	0.00
905	2018338074431	04/10/18 - 04/10/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/11/18 - 04/11/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/13/18 - 04/13/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/16/18 - 04/16/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/18/18 - 04/18/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/20/18 - 04/20/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/23/18 - 04/23/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/25/18 - 04/25/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/27/18 - 04/27/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	04/30/18 - 04/30/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/02/18 - 05/02/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/04/18 - 05/04/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/07/18 - 05/07/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/09/18 - 05/09/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
905	2018338074431	05/11/18 - 05/11/18	12/10/18	0.00	372.00	0.00	6,210.00	0.00
TOTAL				0.00	14,136.00	0.00	237,402.32	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	639,280.06	ADJUSTMENTS	1,238.62
COVERED CHARGES	626,392.87	CONTRACTUAL ALLOW	603,233.71
NON-COVERD CHARGES	12,887.19	TOTAL MEDICAID LIAB	23,159.16
		LESS: COB	0.00
		LESS: COPAYMENT	711.00
		REIMBURSEMENT	22,448.16
		TOTAL NUMBER OF CLAIMS	414

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,815.42	0.00	OTHER LAB	2,786.00	0.00
MED/SURG SUPPLY	1,494.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,435.00	288.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,003.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,125.00	2,411.00
EKG/ECG	8,339.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45,273.00	2,782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,400.00	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	297,560.64	981.24	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,843.19	479.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,836.00	1,096.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,482.00	299.00			

TOTAL ANCILLARY	626,392.87	12,887.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	626,392.87	12,887.19

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,489.48	ADJUSTMENTS	0.00
COVERED CHARGES	8,425.48	CONTRACTUAL ALLOW	3,932.23
NON-COVERD CHARGES	64.00	TOTAL MEDICAID LIAB	4,493.25
		LESS: COB	4,487.25
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	1,119.00	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	1,553.00	22.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	134.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	5,317.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	42.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	8,425.48	64.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,425.48	64.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,812,101.92	ADJUSTMENTS	196,453.08
COVERED CHARGES	5,500,552.83	CONTRACTUAL ALLOW	4,719,879.68
NON-COVERD CHARGES	311,549.09	TOTAL MEDICAID LIAB	780,673.15
		LESS: COB	0.00
		LESS: COPAYMENT	934.74
		REIMBURSEMENT	779,738.41

TOTAL NUMBER OF CLAIMS 135

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145,665.39	0.00	OTHER LAB	5,321.00	2,396.00
MED/SURG SUPPLY	205,180.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	480.00
RADIOLOGY-DIAGNOSTIC	28,613.00	10,721.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,106.00	18,866.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,535.00	6,745.00	FEE SCHEDULE LAB	116,200.00	4,417.00
EKG/ECG	22,085.00	2,179.00	MRI SERVICES	12,691.00	3,584.00
IV THERAPY	268,862.00	44,627.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	659,445.72	15,706.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,354.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,528.00	2,889.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,021.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,187,880.41	13,614.81
RADIOLOGY THERAPEUTIC	583,338.00	4,945.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,500.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	361.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	529,418.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,375.00	6,206.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,570.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	385,506.00	94,652.00			
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	166,165.00	68,090.00			

TOTAL ANCILLARY	5,500,552.83	311,549.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,500,552.83	311,549.09

GEORGIA DEPARTMENT OF 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	87,545.78	ADJUSTMENTS	0.00
COVERED CHARGES	46,620.53	CONTRACTUAL ALLOW	-991.40
NON-COVERD CHARGES	40,925.25	TOTAL MEDICAID LIAB	47,611.93
		LESS: COB	47,605.93
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,320.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,484.32	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	1,276.00	275.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	1,054.25	63.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	25,307.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,216.00	14,108.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,032.00			

TOTAL ANCILLARY	46,620.53	40,925.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	46,620.53	40,925.25

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,049,191.43	ADJUSTMENTS	0.00
COVERED CHARGES	4,891,711.27	CONTRACTUAL ALLOW	4,497,203.62
NON-COVERD CHARGES	157,480.16	TOTAL MEDICAID LIAB	394,507.65
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	394,507.65

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	72	0	62,690.00	155,646.72
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	72	0	62,690.00	155,646.72
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	72	0	62,690.00	155,646.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,289.72	0.00	OTHER LAB	9,080.52	0.00
MED/SURG SUPPLY	18,091.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,410.84	0.00	EDUCATION & TRAINING	620.36	0.00
RADIOLOGY-DIAGNOSTIC	4,057.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,355.61	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,563.89	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,241.85	0.00	MRI SERVICES	7,934.92	0.00
IV THERAPY	2,756.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,949,487.88	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,996.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,166.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	78.64	0.00	INJECTABLE DRUGS	30.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,372.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,619,390.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,440.74
OTHER IMAGING SERVICE	788.94	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,515.12	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	5,292.20	0.00			

TOTAL ANCILLARY	4,829,021.27	1,833.44
TOTAL ACCOMODATIONS	62,690.00	155,646.72
TOTAL CHARGES	4,891,711.27	157,480.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
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
41	2218213000686	07/08/18 - 07/09/18	08/06/18	0.00	1,440.74	0.00	0.00	0.00
TOTAL				0.00	1,440.74	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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	481,262.78	ADJUSTMENTS	0.00
COVERED CHARGES	474,980.78	CONTRACTUAL ALLOW	225,733.34
NON-COVERD CHARGES	6,282.00	TOTAL MEDICAID LIAB	249,247.44
		LESS: COB	249,247.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	2,718.00	6,282.00
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	2,718.00	6,282.00
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	2,718.00	6,282.00

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 TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,602.31	0.00	OTHER LAB	1,300.00	0.00
MED/SURG SUPPLY	1,125.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	405.12	0.00	EDUCATION & TRAINING	47.72	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	1,147.49	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	236,432.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	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	151.96	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	222,489.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	472,262.78	0.00
TOTAL ACCOMODATIONS	2,718.00	6,282.00
TOTAL CHARGES	474,980.78	6,282.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,873,682.68	ADJUSTMENTS	137,377.13
COVERED CHARGES	4,500,293.24	CONTRACTUAL ALLOW	3,986,081.83
NON-COVERD CHARGES	373,389.44	TOTAL MEDICAID LIAB	514,211.41
		LESS: COB	7,965.36
		LESS: COPAYMENT	2,046.00
		REIMBURSEMENT	504,200.05
		ALL OTHER	453,516.34
		FEE SCHEDULE-LAB	50,449.57
		INJECTABLE DRUGS	234.14

TOTAL NUMBER OF CLAIMS 1,715

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,058.49	15.11	OTHER LAB	54,373.23	2,280.52
MED/SURG SUPPLY	6,678.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	238.60
RADIOLOGY-DIAGNOSTIC	96,661.38	1,385.78	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	227,086.23	23,162.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,494.97	12,253.85	FEE SCHEDULE LAB	440,864.66	22,056.60
EKG/ECG	29,316.50	689.80	MRI SERVICES	198,608.97	1,806.56
IV THERAPY	46,153.60	6,438.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,924,151.04	275,741.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,996.02	2,028.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	5,000.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	252,230.48	1,459.70	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	2,036.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,627.67	7,032.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	31,553.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,520.00	606.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,368.00	1,178.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,096.88	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,417.26	10,014.36			

TOTAL ANCILLARY	4,500,293.24	373,389.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,500,293.24	373,389.44

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	33,878.27	ADJUSTMENTS	0.00
COVERED CHARGES	32,026.26	CONTRACTUAL ALLOW	23,138.83
NON-COVERD CHARGES	1,852.01	TOTAL MEDICAID LIAB	8,887.43
		LESS: COB	8,863.43
		LESS: COPAYMENT	24.00
		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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,552.14	0.00	OTHER LAB	2,045.51	500.00
MED/SURG SUPPLY	42.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	826.02	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,073.24	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	883.42	997.72	FEE SCHEDULE LAB	5,509.62	181.84
EKG/ECG	862.25	172.45	MRI SERVICES	3,894.66	0.00
IV THERAPY	811.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,134.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	440.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	950.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,026.26	1,852.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,026.26	1,852.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	151,656.82	ADJUSTMENTS	4,642.00
COVERED CHARGES	147,448.78	CONTRACTUAL ALLOW	136,138.78
NON-COVERD CHARGES	4,208.04	TOTAL MEDICAID LIAB	11,310.00
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	10,941.00
		TOTAL NUMBER OF CLAIMS	193

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,628.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	838.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	95.44
RADIOLOGY-DIAGNOSTIC	10,041.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,854.55	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,931.52	1,567.92
EKG/ECG	1,207.15	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	7,838.48	1,548.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,234.44	392.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,177.47	0.00	SPECIAL SERVICES	0.00	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	6.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	425.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	697.14	0.00			

TOTAL ANCILLARY	147,448.78	4,208.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,448.78	4,208.04

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	522.11	ADJUSTMENTS	0.00
COVERED CHARGES	498.11	CONTRACTUAL ALLOW	298.86
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	199.25
		LESS: COB	199.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	178.56	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	498.11	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	498.11	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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,331,305.63	ADJUSTMENTS	9,708.40
COVERED CHARGES	1,287,982.40	CONTRACTUAL ALLOW	1,201,347.22
NON-COVERD CHARGES	43,323.23	TOTAL MEDICAID LIAB	86,635.18
		LESS: COB	13,190.12
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	73,382.06

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

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,287.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,080.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	374.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,745.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,657.18	FEE SCHEDULE LAB	1,439.76	120.00
EKG/ECG	172.45	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,045,184.88	38,873.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	332.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,500.00	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	13,720.42	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	189,879.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	765.00	0.00			

TOTAL ANCILLARY	1,287,982.40	43,323.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,287,982.40	43,323.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,146,523.07	ADJUSTMENTS	492,661.50
COVERED CHARGES	30,591,605.56	CONTRACTUAL ALLOW	23,661,903.93
NON-COVERD CHARGES	554,917.51	TOTAL MEDICAID LIAB	6,929,701.63
		LESS: COB	75,763.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,853,938.50

TOTAL NUMBER OF ADMISSIONS 743

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,934	0	2,737,900.10	206,860.00
ROUTINE NURSERY	221	0	178,580.00	45,430.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.01
TOTAL ROUTINE	3,155	0	2,916,480.10	252,290.01
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,003	0	2,167,880.00	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	1,003	0	2,167,880.00	0.00
TOTAL ACCOMODATIONS	4,158	0	5,084,360.10	252,290.01

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,246,781.88	0.00	OTHER LAB	100,212.07	0.00
MED/SURG SUPPLY	1,575,740.24	9,910.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,590,934.42	0.00	EDUCATION & TRAINING	542.01	0.00
RADIOLOGY-DIAGNOSTIC	569,676.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,479,889.73	40,264.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	261,449.97	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	181,414.23	0.00	MRI SERVICES	222,268.52	0.00
IV THERAPY	78,423.38	0.00	PROFESSIONAL FEES	0.00	22,016.65
OPERATING ROOM	1,122,041.01	1,206.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	181,117.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	978,603.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	230,170.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	127,798.24	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,972,121.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	142,965.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	88,297.07	0.00	INJECTABLE DRUGS	5,031,993.50	0.00
RADIOLOGY THERAPEUTIC	488.89	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,118.66	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,350.98	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	165,861.40	733.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,056.53	1,558.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	799,903.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	122,085.24	22,257.81			
BLOOD	78,442.26	0.00			
BLOOD STORAGE & PRO.	377,353.24	130,737.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,083.46	36,398.55			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	895,609.61	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,565.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	629,886.19	37,543.50			

TOTAL ANCILLARY	25,507,245.46	302,627.50
TOTAL ACCOMODATIONS	5,084,360.10	252,290.01
TOTAL CHARGES	30,591,605.56	554,917.51

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	154,493.97	ADJUSTMENTS	0.00
COVERED CHARGES	135,374.57	CONTRACTUAL ALLOW	35,938.79
NON-COVERD CHARGES	19,119.40	TOTAL MEDICAID LIAB	99,435.78
		LESS: COB	99,435.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15	0	14,100.00	1,570.00
ROUTINE NURSERY	17	0	15,620.00	11,550.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	32	0	29,720.00	13,120.00
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	32	0	29,720.00	13,120.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,464.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,841.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,306.78	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	761.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,630.11	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	498.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	136.59	0.00	PROFESSIONAL FEES	0.00	5,999.40
OPERATING ROOM	19,100.08	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,000.66	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,142.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,198.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,141.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,966.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	539.75	0.00	INJECTABLE DRUGS	10,160.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	311.92	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	902.89	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,242.63	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,725.27	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,580.84	0.00			

TOTAL ANCILLARY	105,654.57	5,999.40
TOTAL ACCOMODATIONS	29,720.00	13,120.00
TOTAL CHARGES	135,374.57	19,119.40

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	28,840,677.02	ADJUSTMENTS	1,280,365.75
COVERED CHARGES	25,149,876.19	CONTRACTUAL ALLOW	21,614,481.57
NON-COVERD CHARGES	3,690,800.83	TOTAL MEDICAID LIAB	3,535,394.62
		LESS: COB	10,866.77
		LESS: COPAYMENT	12,426.93
		REIMBURSEMENT	3,512,100.92
		ALL OTHER	2,750,882.48
		FEE SCHEDULE-LAB	486,725.15
		INJECTABLE DRUGS	274,493.29

TOTAL NUMBER OF CLAIMS 9,642

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,477,279.46	83,754.60	OTHER LAB	852,139.77	1,382.92
MED/SURG SUPPLY	570,333.70	30,525.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	93.50	EDUCATION & TRAINING	0.00	97.00
RADIOLOGY-DIAGNOSTIC	1,015,786.36	45,082.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,079,113.50	487,206.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,543.32	23,837.80	FEE SCHEDULE LAB	5,481,199.90	311,852.93
EKG/ECG	225,069.80	14,447.22	MRI SERVICES	569,770.46	46,980.39
IV THERAPY	418,147.09	76,318.13	PROFESSIONAL FEES	0.00	16,318.74
OPERATING ROOM	1,478,191.18	353,334.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	162.00
RESPIRATORY SERVICES	128,348.43	30,198.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	316,734.31	3,287.45	AMBULANCE	0.00	0.00
GI SERVICES	479,335.63	48,439.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343,611.08	138,212.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	296,457.79	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,858,201.52	947,771.61
RADIOLOGY THERAPEUTIC	639,079.52	197,533.10	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,418.38	7,227.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,386.88	5,264.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,145.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	106,148.12	31,922.01	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	85,894.75	345,478.35
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	274.00	7,499.52
OTHER IMAGING SERVICE	681,228.69	55,606.73			
BLOOD	20,415.01	0.00			
BLOOD STORAGE & PRO.	135,447.58	18,514.43			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	401,569.75	107,264.49			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	600,873.62	176,340.43			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,371.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	787,504.97	62,700.99			

TOTAL ANCILLARY	25,149,876.19	3,690,800.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,149,876.19	3,690,800.83

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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	2017319001130	11/08/17 - 11/08/17	11/20/17	34.25	0.00	0.00	0.00	20.52
948	2017342065352	11/07/17 - 11/07/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/09/17 - 11/09/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/14/17 - 11/14/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/16/17 - 11/16/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/21/17 - 11/21/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/28/17 - 11/28/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017342065352	11/30/17 - 11/30/17	12/18/17	0.00	277.76	0.00	0.00	0.00
948	2017361003396	11/27/17 - 11/27/17	01/01/18	0.00	277.76	0.00	0.00	0.00
948	2017361003396	11/29/17 - 11/29/17	01/01/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/07/17 - 12/07/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/12/17 - 12/12/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009004866	12/14/17 - 12/14/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009005931	12/06/17 - 12/06/17	01/15/18	0.00	277.76	0.00	0.00	0.00
948	2018009005931	12/13/17 - 12/13/17	01/15/18	0.00	277.76	0.00	0.00	0.00
780	2018074078512	03/07/18 - 03/07/18	03/19/18	34.25	0.00	0.00	0.00	20.52
780	2018088092806	03/21/18 - 03/21/18	04/02/18	34.25	0.00	0.00	0.00	20.52
780	2018103073317	04/04/18 - 04/04/18	04/23/18	34.25	0.00	0.00	0.00	20.52
948	2018127032757	04/09/18 - 04/09/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127032757	04/11/18 - 04/11/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/16/18 - 04/16/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/18/18 - 04/18/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/23/18 - 04/23/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/25/18 - 04/25/18	05/14/18	0.00	277.76	0.00	0.00	0.00
948	2018127033710	04/30/18 - 04/30/18	05/14/18	0.00	277.76	0.00	0.00	0.00
780	2018128076604	04/30/18 - 04/30/18	05/14/18	34.25	0.00	0.00	0.00	20.52
948	2018163017862	05/07/18 - 05/07/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/09/18 - 05/09/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/16/18 - 05/16/18	06/18/18	0.00	277.76	0.00	0.00	0.00
948	2018163017862	05/23/18 - 05/23/18	06/18/18	0.00	277.76	0.00	0.00	0.00
780	2018179084180	05/23/18 - 05/23/18	07/02/18	34.25	0.00	0.00	0.00	20.52
780	2018219066523	07/18/18 - 07/18/18	08/13/18	34.25	0.00	0.00	0.00	20.52
780	2018251023360	08/23/18 - 08/23/18	09/17/18	34.25	0.00	0.00	0.00	20.52
948	2018289073777	08/15/18 - 08/15/18	10/22/18	0.00	277.76	0.00	0.00	0.00
948	2018289073779	08/29/18 - 08/29/18	10/22/18	0.00	277.76	0.00	0.00	0.00
TOTAL				274.00	7,499.52	0.00	0.00	164.16

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	547,912.21	ADJUSTMENTS	0.00
COVERED CHARGES	367,661.52	CONTRACTUAL ALLOW	36,599.76
NON-COVERD CHARGES	180,250.69	TOTAL MEDICAID LIAB	331,061.76
		LESS: COB	330,887.34
		LESS: COPAYMENT	174.42
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 157

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,209.49	3,351.23	OTHER LAB	9,048.07	222.22
MED/SURG SUPPLY	7,246.08	19.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,061.85	1,337.03	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,774.12	58,678.96	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	447.37	4,699.89	FEE SCHEDULE LAB	107,466.68	11,677.25
EKG/ECG	2,739.99	314.25	MRI SERVICES	0.00	7,466.40
IV THERAPY	11,920.23	1,969.75	PROFESSIONAL FEES	0.00	38,913.23
OPERATING ROOM	20,178.55	13,371.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	116.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,922.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,298.38	1,588.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,235.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,187.36	8,871.59
RADIOLOGY THERAPEUTIC	33,275.45	5,856.17	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,404.00	322.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,234.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,280.53	8,150.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,659.01	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,835.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,706.80	5,858.42			
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	16,483.19	2,512.48			

TOTAL ANCILLARY	367,661.52	180,250.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	367,661.52	180,250.69

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	540,801.64	ADJUSTMENTS	7,964.49
COVERED CHARGES	493,453.91	CONTRACTUAL ALLOW	467,983.07
NON-COVERD CHARGES	47,347.73	TOTAL MEDICAID LIAB	25,470.84
		LESS: COB	31.53
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	24,635.31
		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

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,335.20	1,991.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,076.46	2,567.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,015.96	9,040.17	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,323.47	11,925.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	104,734.31	6,034.53
EKG/ECG	4,732.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,573.82	70.48	PROFESSIONAL FEES	0.00	3,950.68
OPERATING ROOM	7,293.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,062.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	215,912.99	3,461.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	683.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,830.55	6,522.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	43.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,229.53	1,739.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	176.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,822.64	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,725.80	0.00			

TOTAL ANCILLARY	493,453.91	47,347.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	493,453.91	47,347.73

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	31,714.73	ADJUSTMENTS	0.00
COVERED CHARGES	16,561.21	CONTRACTUAL ALLOW	-1,525.28
NON-COVERD CHARGES	15,153.52	TOTAL MEDICAID LIAB	18,086.49
		LESS: COB	18,077.49
		LESS: COPAYMENT	9.00
		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

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
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PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	677.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	189.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.43	312.56	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,746.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,492.28	36.77
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	770.02	0.00	PROFESSIONAL FEES	0.00	4,761.80
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,010.79	271.24	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.48	1,024.75
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	88.44	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	0.00	0.00			

TOTAL ANCILLARY	16,561.21	15,153.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,561.21	15,153.52

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,784,615.39	ADJUSTMENTS	184,791.40
COVERED CHARGES	3,499,196.68	CONTRACTUAL ALLOW	3,107,473.48
NON-COVERD CHARGES	285,418.71	TOTAL MEDICAID LIAB	391,723.20
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	391,363.20

TOTAL NUMBER OF CLAIMS 72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,562.91	2,430.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82,399.98	262.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.20	EDUCATION & TRAINING	0.00	97.00
RADIOLOGY-DIAGNOSTIC	2,816.69	6,813.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,277.91	6,925.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,672.15	FEE SCHEDULE LAB	40,819.38	4,799.73
EKG/ECG	996.36	1,802.70	MRI SERVICES	40,009.12	2,913.44
IV THERAPY	12,943.26	578.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	247,341.74	41,013.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,722.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,151.55	1,972.47	AMBULANCE	0.00	0.00
GI SERVICES	13,639.28	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,038.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,245.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,360,958.59	174,801.14
RADIOLOGY THERAPEUTIC	149,391.71	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	637.49	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,089.43	1,022.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	400,074.47	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,007.04	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,830.45	37,154.66			
AMBULATORY SURGERY	4,629.39	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,250.72	459.14			

TOTAL ANCILLARY	3,499,196.68	285,418.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,499,196.68	285,418.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,148,044.13	ADJUSTMENTS	76,471.17
COVERED CHARGES	1,102,345.13	CONTRACTUAL ALLOW	641,780.38
NON-COVERD CHARGES	45,699.00	TOTAL MEDICAID LIAB	460,564.75
		LESS: COB	30,656.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	429,908.27

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	174	0	130,500.00	25,235.00
ROUTINE NURSERY	24	0	15,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	198	0	145,700.00	25,235.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	12	0	15,600.00	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	12	0	15,600.00	0.00
TOTAL ACCOMODATIONS	210	0	161,300.00	25,235.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124,565.00	0.00	OTHER LAB	2,609.00	0.00
MED/SURG SUPPLY	19,911.00	141.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,057.00	0.00	EDUCATION & TRAINING	243.00	0.00
RADIOLOGY-DIAGNOSTIC	35,517.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,740.00
CT SCAN	22,320.00	9,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,385.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,435.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,340.00	0.00	PROFESSIONAL FEES	0.00	853.00
OPERATING ROOM	69,583.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,786.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,434.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,450.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,300.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,995.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,430.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	839.50	120.00	INJECTABLE DRUGS	81,470.00	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	642.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,397.00	3,710.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,093.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,390.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,895.00	3,780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,280.00	0.00			
AUDIOLOGY	3,430.00	0.00			
CARDIOLOGY	17,676.20	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	21,571.47	0.00			

TOTAL ANCILLARY	941,045.13	20,464.00
TOTAL ACCOMODATIONS	161,300.00	25,235.00
TOTAL CHARGES	1,102,345.13	45,699.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,190.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,090.00	CONTRACTUAL ALLOW	-155.37
NON-COVERD CHARGES	100.00	TOTAL MEDICAID LIAB	2,245.37
		LESS: COB	2,245.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	1,500.00	100.00
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	1,500.00	100.00
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	1,500.00	100.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	590.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	590.00	0.00
TOTAL ACCOMODATIONS	1,500.00	100.00
TOTAL CHARGES	2,090.00	100.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,375,783.03	ADJUSTMENTS	89,838.65
COVERED CHARGES	2,294,674.31	CONTRACTUAL ALLOW	1,792,861.71
NON-COVERD CHARGES	81,108.72	TOTAL MEDICAID LIAB	501,812.60
		LESS: COB	136.24
		LESS: COPAYMENT	1,453.60
		REIMBURSEMENT	500,222.76
		ALL OTHER	431,612.32
		FEE SCHEDULE-LAB	52,708.58
		INJECTABLE DRUGS	15,901.86

TOTAL NUMBER OF CLAIMS 1,471

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,247.00	180.00	OTHER LAB	44,754.00	0.00
MED/SURG SUPPLY	10,513.00	251.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143,409.00	3,483.00	OTHER THERAPEUTIC SVC	0.00	1,650.00
CT SCAN	395,880.00	2,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,605.00	860.00	FEE SCHEDULE LAB	325,100.10	12,976.00
EKG/ECG	5,106.00	205.00	MRI SERVICES	44,970.00	0.00
IV THERAPY	42,300.00	7,710.00	PROFESSIONAL FEES	0.00	148.00
OPERATING ROOM	269,198.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,100.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,547.00	1,719.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,370.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,100.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	508,902.64	24,635.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	117,721.26	9,862.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	456.00	55.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	578.00	191.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,775.00	4,778.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,365.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,670.40	3,172.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,698.00	2,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,950.00	2,181.60			
AUDIOLOGY	245.00	0.00			
CARDIOLOGY	19,921.40	1,500.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,322.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,070.51	1,020.00			

TOTAL ANCILLARY	2,294,674.31	81,108.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,294,674.31	81,108.72

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	67,676.91	ADJUSTMENTS	0.00
COVERED CHARGES	51,316.91	CONTRACTUAL ALLOW	8,062.73
NON-COVERD CHARGES	16,360.00	TOTAL MEDICAID LIAB	43,254.18
		LESS: COB	43,243.88
		LESS: COPAYMENT	10.30
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,518.00	0.00	OTHER LAB	250.00	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	2,715.00	0.00	OTHER THERAPEUTIC SVC	0.00	450.00
CT SCAN	3,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,059.90	188.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,040.00	2,370.00
IV THERAPY	1,140.00	0.00	PROFESSIONAL FEES	0.00	1,080.00
OPERATING ROOM	4,727.00	9,854.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,895.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,249.41	540.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	939.00	130.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,153.60	540.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,380.00	108.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100.00	0.00			

TOTAL ANCILLARY	51,316.91	16,360.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,316.91	16,360.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	95,007.95	ADJUSTMENTS	211.76
COVERED CHARGES	93,615.95	CONTRACTUAL ALLOW	87,686.31
NON-COVERD CHARGES	1,392.00	TOTAL MEDICAID LIAB	5,929.64
		LESS: COB	44.47
		LESS: COPAYMENT	217.20
		REIMBURSEMENT	5,667.97
		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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,440.00	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	6,510.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,660.00	828.00
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	50,369.95	480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,176.00	84.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	900.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	93,615.95	1,392.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,615.95	1,392.00

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,359.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,343.08	CONTRACTUAL ALLOW	1,726.09
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	616.99
		LESS: COB	616.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.00	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	867.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,386.08	0.00	SPECIAL SERVICES	0.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,343.08	16.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,343.08	16.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY
35 HOSPITAL RD
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	211,608.12	ADJUSTMENTS	5,434.60
COVERED CHARGES	211,057.12	CONTRACTUAL ALLOW	178,413.52
NON-COVERD CHARGES	551.00	TOTAL MEDICAID LIAB	32,643.60
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	32,544.60

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,810.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	20.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105.00	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	748.00	16.00
EKG/ECG	205.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,680.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,788.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	450.00	450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,375.00	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	1,175.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	163,921.12	65.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	12,800.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	211,057.12	551.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,057.12	551.00

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

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 05/01/17 THROUGH 04/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	52,548,838.82	ADJUSTMENTS	781,992.31
COVERED CHARGES	52,207,136.03	CONTRACTUAL ALLOW	36,449,758.69
NON-COVERD CHARGES	341,702.79	TOTAL MEDICAID LIAB	15,757,377.34
		LESS: COB	224,152.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,533,225.23

TOTAL NUMBER OF ADMISSIONS 1,450

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,358	0	1,947,640.00	300.00
ROUTINE NURSERY	476	0	410,799.00	1,453.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,834	0	2,358,439.00	1,753.00
SPECIAL CARE SERVICES				
CCU	160	0	260,000.00	0.00
ICU	4,790	0	5,065,744.00	0.00
NICU	312	0	509,262.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,262	0	5,835,006.00	0.00
TOTAL ACCOMODATIONS	9,096	0	8,193,445.00	1,753.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,776,354.04	827.42	OTHER LAB	365,177.00	0.00
MED/SURG SUPPLY	7,459,945.65	195,361.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,757,523.68	0.00	EDUCATION & TRAINING	28,898.00	0.00
RADIOLOGY-DIAGNOSTIC	1,119,660.00	0.00	OTHER THERAPEUTIC SVC	69,429.00	20,671.00
CT SCAN	2,595,373.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	291,387.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	341,619.00	0.00	MRI SERVICES	593,285.00	0.00
IV THERAPY	308,262.00	814.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,107,857.00	8,153.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	96,800.00	0.00	REHAB THERAPY	3,540.00	0.00
RESPIRATORY SERVICES	3,083,474.00	624.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	234,436.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	279,928.00	2,801.00	CAST ROOM	460.00	0.00
EMERGENCY ROOM	1,156,825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,612.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	174,287.45	0.00	INJECTABLE DRUGS	7,015.92	0.00
RADIOLOGY THERAPEUTIC	23,688.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	135,599.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	74,338.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	366,120.00	20,250.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,044.00	3,560.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,928,106.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	15,678.00
OTHER IMAGING SERVICE	224,498.00	4,900.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	565,845.00	7,784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	229,373.00	57,312.00			
AUDIOLOGY	18,902.00	0.00			
CARDIOLOGY	1,873,068.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,775.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	452,186.00	1,214.00			

TOTAL ANCILLARY	44,013,691.03	339,949.79
TOTAL ACCOMODATIONS	8,193,445.00	1,753.00
TOTAL CHARGES	52,207,136.03	341,702.79

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 01/01/18 THROUGH 12/31/18
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	2018158014678	05/24/18 - 05/31/18	06/11/18	0.00	2,613.00	0.00	0.00	0.00
615	2018158014723	05/25/18 - 05/31/18	06/11/18	0.00	2,613.00	0.00	0.00	0.00
615	2018250033293	08/22/18 - 08/29/18	09/10/18	0.00	2,613.00	0.00	0.00	0.00
615	2018345028726	05/22/18 - 06/04/18	12/17/18	0.00	2,613.00	0.00	0.00	0.00
615	2019065033743	10/05/18 - 10/07/18	03/11/19	0.00	2,613.00	0.00	0.00	0.00
615	2019178043029	09/17/18 - 09/17/18	07/01/19	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	15,678.00	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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	370,399.28	ADJUSTMENTS	0.00
COVERED CHARGES	370,399.28	CONTRACTUAL ALLOW	173,730.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	196,668.41
		LESS: COB	196,668.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	39	0	22,620.00	0.00
ROUTINE NURSERY	21	0	18,345.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	40,965.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	9	0	9,959.00	0.00
NICU	1	0	1,625.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	11,584.00	0.00
TOTAL ACCOMODATIONS	70	0	52,549.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,947.11	0.00	OTHER LAB	2,034.00	0.00
MED/SURG SUPPLY	71,802.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,251.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,693.00	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	4,454.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,483.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,538.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,097.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,251.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,186.06	0.00	INJECTABLE DRUGS	9.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	756.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,800.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,685.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	954.00	0.00			
CARDIOLOGY	57,074.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,707.00	0.00			

TOTAL ANCILLARY	317,850.28	0.00
TOTAL ACCOMODATIONS	52,549.00	0.00
TOTAL CHARGES	370,399.28	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	22,254,936.21	ADJUSTMENTS	1,046,120.85
COVERED CHARGES	20,609,470.41	CONTRACTUAL ALLOW	16,635,702.90
NON-COVERD CHARGES	1,645,465.80	TOTAL MEDICAID LIAB	3,973,767.51
		LESS: COB	39,329.51
		LESS: COPAYMENT	14,617.30
		REIMBURSEMENT	3,919,820.70
		ALL OTHER	3,109,743.13
		FEE SCHEDULE-LAB	416,257.84
		INJECTABLE DRUGS	393,819.73

TOTAL NUMBER OF CLAIMS 12,250

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	929,130.70	5,434.67	OTHER LAB	581,467.00	133.00
MED/SURG SUPPLY	2,091,466.48	30,825.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	38.00	EDUCATION & TRAINING	99.00	2,798.00
RADIOLOGY-DIAGNOSTIC	948,006.00	34,814.00	OTHER THERAPEUTIC SVC	896.00	602.00
CT SCAN	2,501,162.00	363,321.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,176.00	9,527.00	FEE SCHEDULE LAB	2,692,918.26	113,443.78
EKG/ECG	357,363.00	2,768.00	MRI SERVICES	637,858.00	45,788.00
IV THERAPY	1,079,943.00	61,722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,410,660.96	269,707.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,346.00	0.00	REHAB THERAPY	0.00	90.00
RESPIRATORY SERVICES	98,542.00	8,139.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	91,778.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	163,796.50	31,103.50	CAST ROOM	18,026.00	1,380.00
EMERGENCY ROOM	2,926,327.00	4,296.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	139,971.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,507,787.05	327,539.78
RADIOLOGY THERAPEUTIC	14,982.00	567.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,529.00	6,845.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,442.00	4,209.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,720.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	269,731.00	73,120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	97,331.98	13,021.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,813.00
OTHER IMAGING SERVICE	543,644.00	43,231.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,502.48	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	387,110.00	48,565.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	668,023.00	123,658.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,576.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296,879.00	1,659.00			

TOTAL ANCILLARY	20,609,470.41	1,645,465.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,609,470.41	1,645,465.80

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 01/01/18 THROUGH 12/31/18
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	2018197023737	06/20/18 - 06/20/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023738	06/21/18 - 06/21/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023739	06/25/18 - 06/25/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023740	07/02/18 - 07/02/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023742	07/09/18 - 07/09/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018197023744	07/11/18 - 07/11/18	07/23/18	0.00	525.00	0.00	0.00	0.00
948	2018226031853	07/12/18 - 07/12/18	08/20/18	0.00	525.00	0.00	0.00	0.00
948	2018226031854	07/16/18 - 07/16/18	08/20/18	0.00	525.00	0.00	0.00	0.00
615	2019162024905	12/10/18 - 12/10/18	06/17/19	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	6,813.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	252,159.17	ADJUSTMENTS	0.00
COVERED CHARGES	211,446.45	CONTRACTUAL ALLOW	125,527.57
NON-COVERD CHARGES	40,712.72	TOTAL MEDICAID LIAB	85,918.88
		LESS: COB	85,816.88
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 97

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,159.83	0.00	OTHER LAB	1,877.00	0.00
MED/SURG SUPPLY	28,545.46	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,774.00	599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,050.00	17,520.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.00	FEE SCHEDULE LAB	26,507.92	1,824.57
EKG/ECG	1,572.00	0.00	MRI SERVICES	13,277.00	0.00
IV THERAPY	17,535.00	945.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,226.00	4,705.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,215.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	450.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,347.00	825.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,261.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,501.24	5,685.15
RADIOLOGY THERAPEUTIC	591.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,164.00	177.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,806.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,306.00	5,792.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,393.00	2,088.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	888.00	137.00			

TOTAL ANCILLARY	211,446.45	40,712.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	211,446.45	40,712.72

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	352,134.43	ADJUSTMENTS	6,800.14
COVERED CHARGES	341,815.38	CONTRACTUAL ALLOW	314,279.57
NON-COVERD CHARGES	10,319.05	TOTAL MEDICAID LIAB	27,535.81
		LESS: COB	147.20
		LESS: COPAYMENT	756.00
		REIMBURSEMENT	26,632.61

TOTAL NUMBER OF CLAIMS 451

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,141.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,623.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,896.00	1,936.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,472.00	3,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	588.00	FEE SCHEDULE LAB	67,175.56	1,530.14
EKG/ECG	5,764.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	24,092.00	189.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,783.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	214.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	174,898.00	986.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	920.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,389.32	167.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,446.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	341,815.38	10,319.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	341,815.38	10,319.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,666.59	ADJUSTMENTS	0.00
COVERED CHARGES	15,870.59	CONTRACTUAL ALLOW	11,729.07
NON-COVERD CHARGES	3,796.00	TOTAL MEDICAID LIAB	4,141.52
		LESS: COB	4,126.52
		LESS: COPAYMENT	15.00
		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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	994.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	485.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,136.00	3,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,783.04	60.00
EKG/ECG	524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,094.00	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	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	5,168.00	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	761.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,870.59	3,796.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,870.59	3,796.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,275,224.50	ADJUSTMENTS	255,925.89
COVERED CHARGES	3,318,966.32	CONTRACTUAL ALLOW	2,586,046.94
NON-COVERD CHARGES	956,258.18	TOTAL MEDICAID LIAB	732,919.38
		LESS: COB	4,959.06
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	727,480.32

TOTAL NUMBER OF CLAIMS 134

GEORGIA 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,583.18	0.00	OTHER LAB	175.00	0.00
MED/SURG SUPPLY	603,600.77	231,318.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	98.00	0.00
RADIOLOGY-DIAGNOSTIC	77,791.00	35,101.00	OTHER THERAPEUTIC SVC	0.00	71.00
CT SCAN	3,736.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	675.00	FEE SCHEDULE LAB	31,043.46	450.00
EKG/ECG	3,668.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	53,586.00	2,079.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	643,084.66	551,894.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	495.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,665.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,552.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,125,487.31	50,373.66
RADIOLOGY THERAPEUTIC	1,323.00	567.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	810.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	488,753.94	25,425.72
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,599.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,256.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,730.00	480.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	191,160.00	56,824.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,754.00	0.00			

TOTAL ANCILLARY	3,318,966.32	956,258.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,318,966.32	956,258.18

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,998,148.94	ADJUSTMENTS	100,075.12
COVERED CHARGES	12,792,760.07	CONTRACTUAL ALLOW	9,548,988.61
NON-COVERD CHARGES	205,388.87	TOTAL MEDICAID LIAB	3,243,771.46
		LESS: COB	30,856.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,212,915.01

TOTAL NUMBER OF ADMISSIONS 378

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,095	0	1,173,162.00	172,143.00
ROUTINE NURSERY	62	0	51,274.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	11,067.00
TOTAL ROUTINE	1,157	0	1,224,436.00	183,210.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	618	0	1,361,778.00	0.00
NICU	12	0	18,852.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	1,380,630.00	0.00
TOTAL ACCOMODATIONS	1,787	0	2,605,066.00	183,210.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518,080.78	19.50	OTHER LAB	12,832.00	0.00
MED/SURG SUPPLY	469,829.39	1,251.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,088,247.00	0.00	EDUCATION & TRAINING	195.00	0.00
RADIOLOGY-DIAGNOSTIC	296,013.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	850,259.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	243,984.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	159,110.00	0.00	MRI SERVICES	112,365.35	0.00
IV THERAPY	230,704.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,729,471.00	10,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,204.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,510,647.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,186.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	86,600.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	567,378.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	263,791.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,739.00
LABORATORY PATHOLOGIC	33,040.00	0.00	INJECTABLE DRUGS	894,224.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,227.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	73,620.00	0.00	PATIENT CONVENIENCE	0.00	36.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,640.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	510,112.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,607.51
OTHER IMAGING SERVICE	45,174.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,275.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,889.00	3,508.00			
AUDIOLOGY	3,762.00	903.72			
CARDIOLOGY	135,125.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,076.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,632.00	0.00			

TOTAL ANCILLARY	10,187,694.07	22,178.87
TOTAL ACCOMODATIONS	2,605,066.00	183,210.00
TOTAL CHARGES	12,792,760.07	205,388.87

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 01/01/18 THROUGH 12/31/18
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
951	2018179037151	06/21/18 - 06/25/18	07/02/18	0.00	288.00	0.00	0.00	0.00
-1	2318331000439	09/23/18 - 09/26/18	12/10/18	0.00	2,319.51	0.00	874.26	0.00
TOTAL				0.00	2,607.51	0.00	874.26	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	40,909.58	ADJUSTMENTS	0.00
COVERED CHARGES	40,909.58	CONTRACTUAL ALLOW	17,998.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	22,911.41
		LESS: COB	22,911.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2	0	2,136.00	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	2,136.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3	0	6,063.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	6,063.00	0.00
TOTAL ACCOMODATIONS	5	0	8,199.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,489.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	914.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,886.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,295.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,735.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,847.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,768.00	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	3,678.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,440.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	32,710.58	0.00
TOTAL ACCOMODATIONS	8,199.00	0.00
TOTAL CHARGES	40,909.58	0.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	12,364,839.69	ADJUSTMENTS	772,688.59
COVERED CHARGES	11,787,307.85	CONTRACTUAL ALLOW	9,996,866.20
NON-COVERD CHARGES	577,531.84	TOTAL MEDICAID LIAB	1,790,441.65
		LESS: COB	3,660.59
		LESS: COPAYMENT	4,373.35
		REIMBURSEMENT	1,782,407.71
		ALL OTHER	1,589,666.96
		FEE SCHEDULE-LAB	176,168.91
		INJECTABLE DRUGS	16,571.84

TOTAL NUMBER OF CLAIMS 4,070

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,805.09	4,102.08	OTHER LAB	77,259.00	3,381.00
MED/SURG SUPPLY	194,110.48	6,243.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	614,021.00	16,147.00	OTHER THERAPEUTIC SVC	0.00	1,840.00
CT SCAN	2,037,426.85	76,417.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264,847.00	37,522.04	FEE SCHEDULE LAB	1,799,483.50	29,771.00
EKG/ECG	338,997.00	21,546.00	MRI SERVICES	194,870.75	6,548.35
IV THERAPY	567,427.00	49,532.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,174,492.76	197,488.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,536.00	0.00	REHAB THERAPY	161.00	0.00
RESPIRATORY SERVICES	46,543.00	25,999.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,330.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	160,210.00	4,330.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,674,679.00	620.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	249,117.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	256,112.81	47,279.19
RADIOLOGY THERAPEUTIC	456.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,556.00	618.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,090.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,025.00	6,600.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	111,474.61	0.00
LITHOTRIPSY	23,751.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	173,241.00	20,316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,388.00	1,657.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,557.00	4,565.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	60,260.00	1,110.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	159,175.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	270,995.00	9,808.00			

TOTAL ANCILLARY	11,787,307.85	577,531.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,787,307.85	577,531.84

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	134,831.17	ADJUSTMENTS	0.00
COVERED CHARGES	88,756.25	CONTRACTUAL ALLOW	40,346.89
NON-COVERD CHARGES	46,074.92	TOTAL MEDICAID LIAB	48,409.36
		LESS: COB	48,395.52
		LESS: COPAYMENT	13.84
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.80	263.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,526.90	384.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,180.00	895.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,232.35	17,204.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,153.00	1,919.00
EKG/ECG	1,026.00	1,026.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,792.00	178.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,237.25	17,518.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,524.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	119.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,954.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,837.00	256.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,522.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,580.10	679.40
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	51.85	3,258.92
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	776.00	1,588.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,184.00	784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	88,756.25	46,074.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,756.25	46,074.92

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,832.83	ADJUSTMENTS	8,027.48
COVERED CHARGES	415,767.56	CONTRACTUAL ALLOW	394,588.18
NON-COVERD CHARGES	3,065.27	TOTAL MEDICAID LIAB	21,179.38
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	20,444.38
		TOTAL NUMBER OF CLAIMS	329

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,043.98	10.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,438.66	1,069.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,537.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,125.05	875.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,686.00	730.00
EKG/ECG	6,669.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,675.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	290,221.00	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	6,371.87	379.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	415,767.56	3,065.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	415,767.56	3,065.27

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,560.65	ADJUSTMENTS	0.00
COVERED CHARGES	10,514.65	CONTRACTUAL ALLOW	4,620.11
NON-COVERD CHARGES	46.00	TOTAL MEDICAID LIAB	5,894.54
		LESS: COB	5,888.54
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	975.00	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	2,880.00	10.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	966.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	5,043.00	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	137.65	36.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	10,514.65	46.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,514.65	46.00

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	606,563.64	ADJUSTMENTS	49,874.06
COVERED CHARGES	478,002.90	CONTRACTUAL ALLOW	411,460.14
NON-COVERD CHARGES	128,560.74	TOTAL MEDICAID LIAB	66,542.76
		LESS: COB	0.00
		LESS: COPAYMENT	41.06
		REIMBURSEMENT	66,501.70
		TOTAL NUMBER OF CLAIMS	12

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,369.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53,395.85	134.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,204.00	5,953.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,368.00	0.00
EKG/ECG	3,078.00	513.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,303.00	1,068.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	206,470.75	114,737.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,713.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,448.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,908.54	5,231.49
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	119,967.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	429.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,980.00	924.00			

TOTAL ANCILLARY	478,002.90	128,560.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	478,002.90	128,560.74

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	13,853,641.66	ADJUSTMENTS	349,762.35
COVERED CHARGES	13,669,895.36	CONTRACTUAL ALLOW	9,162,545.17
NON-COVERD CHARGES	183,746.30	TOTAL MEDICAID LIAB	4,507,350.19
		LESS: COB	26,395.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,480,954.99

TOTAL NUMBER OF ADMISSIONS 637

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,341	0	860,368.00	66,629.00
ROUTINE NURSERY	265	0	148,717.00	662.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,606	0	1,009,085.00	67,291.00
SPECIAL CARE SERVICES				
CCU	707	0	726,920.00	0.00
ICU	388	0	538,950.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,095	0	1,265,870.00	0.00
TOTAL ACCOMODATIONS	2,701	0	2,274,955.00	67,291.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,278,185.95	1,726.96	OTHER LAB	53,182.00	0.00
MED/SURG SUPPLY	1,071,142.14	3,665.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,179,184.00	672.00	EDUCATION & TRAINING	5,077.00	0.00
RADIOLOGY-DIAGNOSTIC	196,405.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	669,877.00	13,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,573.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	126,317.00	0.00	MRI SERVICES	59,433.00	0.00
IV THERAPY	196,221.24	720.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	657,212.00	1,843.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	198,568.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,073,481.00	3,740.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,078.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	94,303.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	438,828.00	1,272.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	73,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	38,266.00	0.00	INJECTABLE DRUGS	575.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,082.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,128.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	442,170.00	54,621.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	322.00	19,679.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	457,932.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	91,828.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	179,452.00	6,480.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	115,726.00	8,336.00			
AUDIOLOGY	15,116.00	0.00			
CARDIOLOGY	216,315.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,026.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	208,679.00	0.00			

TOTAL ANCILLARY	11,394,940.36	116,455.30
TOTAL ACCOMODATIONS	2,274,955.00	67,291.00
TOTAL CHARGES	13,669,895.36	183,746.30

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	43,197.27	ADJUSTMENTS	0.00
COVERED CHARGES	40,425.27	CONTRACTUAL ALLOW	5,684.22
NON-COVERD CHARGES	2,772.00	TOTAL MEDICAID LIAB	34,741.05
		LESS: COB	34,741.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	9	0	5,817.00	570.00
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	5,817.00	570.00
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	5,817.00	570.00

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,946.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,380.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,286.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,252.00	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	653.00	0.00	PROFESSIONAL FEES	0.00	2,202.00
OPERATING ROOM	5,266.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	263.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	784.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	347.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84.00	0.00			

TOTAL ANCILLARY	34,608.27	2,202.00
TOTAL ACCOMODATIONS	5,817.00	570.00
TOTAL CHARGES	40,425.27	2,772.00

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,099,508.26	ADJUSTMENTS	567,065.47
COVERED CHARGES	8,871,785.31	CONTRACTUAL ALLOW	6,972,503.68
NON-COVERD CHARGES	1,227,722.95	TOTAL MEDICAID LIAB	1,899,281.63
		LESS: COB	751.18
		LESS: COPAYMENT	5,955.13
		REIMBURSEMENT	1,892,575.32
		ALL OTHER	1,298,586.51
		FEE SCHEDULE-LAB	221,678.98
		INJECTABLE DRUGS	372,309.83

TOTAL NUMBER OF CLAIMS 5,052

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286,893.56	570.48	OTHER LAB	88,847.00	0.00
MED/SURG SUPPLY	381,244.86	5,289.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,227.00
RADIOLOGY-DIAGNOSTIC	324,420.00	15,667.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,255,908.00	87,681.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,905.00	8,359.05	FEE SCHEDULE LAB	1,328,590.86	98,993.00
EKG/ECG	126,603.00	711.00	MRI SERVICES	195,228.00	20,648.00
IV THERAPY	259,504.00	66,479.00	PROFESSIONAL FEES	0.00	2,955.00
OPERATING ROOM	503,335.38	80,798.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,167.50	19,506.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,482.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	186,466.00	75,152.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	867,233.00	5,689.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,295,445.64	386,660.46
RADIOLOGY THERAPEUTIC	25,360.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,571.00	1,758.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,960.00	954.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	345,887.00	51,739.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,677.00	179,256.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	102.00
OTHER IMAGING SERVICE	159,001.00	6,455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,680.00	5,826.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	289,327.00	43,840.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	248,582.00	56,861.00			
AMBULATORY SURGERY	1,322.88	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,395.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	233,848.00	4,546.00			

TOTAL ANCILLARY	8,871,785.31	1,227,722.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,871,785.31	1,227,722.95

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
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
9636	5917338000543	10/11/17 - 10/11/17	12/11/17	0.00	102.00	0.00	0.00	0.00
TOTAL				0.00	102.00	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

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	172,516.34	ADJUSTMENTS	0.00
COVERED CHARGES	119,325.58	CONTRACTUAL ALLOW	15,970.48
NON-COVERD CHARGES	53,190.76	TOTAL MEDICAID LIAB	103,355.10
		LESS: COB	103,308.88
		LESS: COPAYMENT	46.22
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 89

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,218.50	591.50	OTHER LAB	3,138.00	0.00
MED/SURG SUPPLY	6,960.88	791.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,839.00	1,617.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,609.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,508.00	2,224.00
EKG/ECG	1,422.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,621.00	392.00	PROFESSIONAL FEES	0.00	15,783.00
OPERATING ROOM	15,103.00	10,768.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,666.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,947.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,014.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,258.00	359.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,528.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,886.20	11,956.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,376.00	6,130.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,411.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,598.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,633.00	168.00			

TOTAL ANCILLARY	119,325.58	53,190.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,325.58	53,190.76

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	418,568.16	ADJUSTMENTS	8,008.90
COVERED CHARGES	397,300.85	CONTRACTUAL ALLOW	379,075.25
NON-COVERD CHARGES	21,267.31	TOTAL MEDICAID LIAB	18,225.60
		LESS: COB	0.00
		LESS: COPAYMENT	546.00
		REIMBURSEMENT	17,679.60

TOTAL NUMBER OF CLAIMS 291

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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,696.06	0.00	OTHER LAB	1,199.00	0.00
MED/SURG SUPPLY	11,117.00	263.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,376.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,294.00	8,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	669.02	FEE SCHEDULE LAB	99,558.00	4,294.00
EKG/ECG	6,873.00	0.00	MRI SERVICES	3,003.00	0.00
IV THERAPY	13,284.00	1,372.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,414.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,851.00	157.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,722.79	4,772.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	707.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,429.00	1,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,777.00	0.00			

TOTAL ANCILLARY	397,300.85	21,267.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	397,300.85	21,267.31

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,581.16	ADJUSTMENTS	0.00
COVERED CHARGES	5,689.40	CONTRACTUAL ALLOW	1,954.57
NON-COVERD CHARGES	2,891.76	TOTAL MEDICAID LIAB	3,734.83
		LESS: COB	3,731.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	248.00	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	1,355.00	28.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	434.00	0.00	PROFESSIONAL FEES	0.00	2,684.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	2,571.00	132.00	SPECIAL SERVICES	0.00	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	47.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	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	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	5,689.40	2,891.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,689.40	2,891.76

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	540,250.47	ADJUSTMENTS	27,182.00
COVERED CHARGES	464,115.21	CONTRACTUAL ALLOW	360,743.81
NON-COVERD CHARGES	76,135.26	TOTAL MEDICAID LIAB	103,371.40
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	103,323.40

TOTAL NUMBER OF CLAIMS 19

GEORGIA 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 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,232.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,764.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,889.00	11,607.00	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	1,453.00	438.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,210.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	356,456.45	53,624.26
RADIOLOGY THERAPEUTIC	4,681.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,087.00	207.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	9,473.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	511.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	625.00	786.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	464,115.21	76,135.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	464,115.21	76,135.26

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
3131 THOMASVILLE HWY
MOULTRIE,GA 31776-6925

PROVIDER NUMBER
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/17 THROUGH 09/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,820,740.21	ADJUSTMENTS	207,308.21
COVERED CHARGES	19,811,788.21	CONTRACTUAL ALLOW	12,781,201.01
NON-COVERD CHARGES	8,952.00	TOTAL MEDICAID LIAB	7,030,587.20
		LESS: COB	29,713.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,000,873.25

TOTAL NUMBER OF ADMISSIONS 1,440

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,582	0	10,346,906.00	0.00
ROUTINE NURSERY	106	0	80,984.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,688	0	10,427,890.00	0.00
SPECIAL CARE SERVICES				
CCU	354	0	684,062.00	0.00
ICU	160	0	476,160.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	514	0	1,160,222.00	0.00
TOTAL ACCOMODATIONS	9,202	0	11,588,112.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,525,725.39	0.00	OTHER LAB	34,629.25	0.00
MED/SURG SUPPLY	153,675.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,997,823.78	0.00	EDUCATION & TRAINING	5,570.00	0.00
RADIOLOGY-DIAGNOSTIC	124,172.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	430,424.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,913.94	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	93,394.00	0.00	MRI SERVICES	135,891.00	0.00
IV THERAPY	203,931.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,817.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,514.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555,038.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,959.00	0.00	AMBULANCE	0.00	2,568.00
GI SERVICES	70,286.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	683,548.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,025.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,587.00	0.00	INJECTABLE DRUGS	783,780.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	295.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,564.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,252.00	5,796.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,472.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	11,160.00	0.00	IMPL DEV CHARGE PATIENTS	159,970.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,689.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	73,003.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,445.00	0.00			
AUDIOLOGY	2,576.00	0.00			
CARDIOLOGY	552,966.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,652.00	588.00			

TOTAL ANCILLARY	8,223,676.21	8,952.00
TOTAL ACCOMODATIONS	11,588,112.00	0.00
TOTAL CHARGES	19,811,788.21	8,952.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	109,687.35	ADJUSTMENTS	0.00
COVERED CHARGES	109,687.35	CONTRACTUAL ALLOW	64,138.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	45,549.05
		LESS: COB	45,549.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	26	0	31,226.00	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	31,226.00	0.00
SPECIAL CARE SERVICES				
CCU	2	0	3,858.00	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	3,858.00	0.00
TOTAL ACCOMODATIONS	28	0	35,084.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,814.99	0.00	OTHER LAB	1,513.00	0.00
MED/SURG SUPPLY	3,640.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,203.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,002.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	538.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	943.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	1,446.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	269.96	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,150.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,588.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	74,603.35	0.00
TOTAL ACCOMODATIONS	35,084.00	0.00
TOTAL CHARGES	109,687.35	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,489,873.51	ADJUSTMENTS	363,496.27
COVERED CHARGES	9,871,702.61	CONTRACTUAL ALLOW	7,868,382.88
NON-COVERD CHARGES	618,170.90	TOTAL MEDICAID LIAB	2,003,319.73
		LESS: COB	2,350.27
		LESS: COPAYMENT	4,641.00
		REIMBURSEMENT	1,996,328.46
		ALL OTHER	1,829,285.12
		FEE SCHEDULE-LAB	99,319.51
		INJECTABLE DRUGS	67,723.83

TOTAL NUMBER OF CLAIMS 3,195

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	289,042.78	0.00	OTHER LAB	76,751.50	0.00
MED/SURG SUPPLY	106,869.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,895.00
RADIOLOGY-DIAGNOSTIC	369,647.00	8,608.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,109,525.00	108,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,495.00	19,614.00	FEE SCHEDULE LAB	1,110,095.00	26,240.00
EKG/ECG	118,626.00	4,304.00	MRI SERVICES	274,419.00	18,594.00
IV THERAPY	715,861.00	65,656.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	483,463.44	45,846.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103,782.00	1,530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,517.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	223,542.00	2,639.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,750,734.28	13,610.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,029.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	672,147.59	108,747.78
RADIOLOGY THERAPEUTIC	914.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	497.00	1,988.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,932.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	299.00	3,506.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,087,232.00	1,240.00	IMPL DEV CHARGE PATIENTS	31,275.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,969.00	38,567.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,394.00	910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	230,276.00	43,755.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	424,288.00	48,553.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	101,521.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	254,490.00	52,281.00			

TOTAL ANCILLARY	9,871,702.61	618,170.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,871,702.61	618,170.90

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	222,983.48	ADJUSTMENTS	0.00
COVERED CHARGES	165,855.43	CONTRACTUAL ALLOW	44,786.56
NON-COVERD CHARGES	57,128.05	TOTAL MEDICAID LIAB	121,068.87
		LESS: COB	120,975.87
		LESS: COPAYMENT	93.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,839.46	75.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	218.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,527.00	1,337.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,265.00	19,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,106.00	1,095.00
EKG/ECG	807.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,982.00	167.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,460.50	1,902.50	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	2,758.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,546.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	714.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,446.07	24,982.55
RADIOLOGY THERAPEUTIC	1,548.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	14,508.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,175.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,638.00	1,650.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,785.00	730.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,035.00	1,885.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,872.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	2,494.00			

TOTAL ANCILLARY	165,855.43	57,128.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	165,855.43	57,128.05

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	359,398.89	ADJUSTMENTS	541.40
COVERED CHARGES	356,032.94	CONTRACTUAL ALLOW	342,103.88
NON-COVERD CHARGES	3,365.95	TOTAL MEDICAID LIAB	13,929.06
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	13,560.06
		TOTAL NUMBER OF CLAIMS	249

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,088.16	0.00	OTHER LAB	806.00	0.00
MED/SURG SUPPLY	291.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,593.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,818.00	1,896.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,638.00	824.00
EKG/ECG	2,152.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,850.00	334.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,400.00	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	173,978.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,499.74	311.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,918.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	356,032.94	3,365.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	356,032.94	3,365.95

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,615.48	ADJUSTMENTS	0.00
COVERED CHARGES	13,753.48	CONTRACTUAL ALLOW	-2,657.57
NON-COVERD CHARGES	10,862.00	TOTAL MEDICAID LIAB	16,411.05
		LESS: COB	16,405.05
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	71.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	756.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,796.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,533.00	66.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,302.00	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	8,428.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	438.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	13,753.48	10,862.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,753.48	10,862.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,540,123.30	ADJUSTMENTS	80,526.86
COVERED CHARGES	2,493,353.15	CONTRACTUAL ALLOW	1,607,464.16
NON-COVERD CHARGES	46,770.15	TOTAL MEDICAID LIAB	885,888.99
		LESS: COB	26,173.56
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	859,283.43

TOTAL NUMBER OF CLAIMS 154

GEORGIA 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,729.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,952.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	135.00
RADIOLOGY-DIAGNOSTIC	2,608.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,876.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	555.00	FEE SCHEDULE LAB	16,522.20	851.00
EKG/ECG	3,497.00	538.00	MRI SERVICES	0.00	0.00
IV THERAPY	131,597.00	5,835.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	137,611.50	19,379.50	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	20,430.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,528.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,231.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,618.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,930,156.06	926.65
RADIOLOGY THERAPEUTIC	5,072.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	47,539.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,980.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	57,152.00	12,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,780.00	0.00			

TOTAL ANCILLARY	2,493,353.15	46,770.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,493,353.15	46,770.15

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	163,979.04	ADJUSTMENTS	0.00
COVERED CHARGES	163,979.04	CONTRACTUAL ALLOW	95,472.63
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	68,506.41
		LESS: COB	68,497.41
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	980.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	157,815.94	0.00
RADIOLOGY THERAPEUTIC	4,850.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	163,979.04	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	163,979.04	0.00

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,507,070.83	ADJUSTMENTS	80,400.41
COVERED CHARGES	5,483,462.83	CONTRACTUAL ALLOW	3,970,542.01
NON-COVERD CHARGES	23,608.00	TOTAL MEDICAID LIAB	1,512,920.82
		LESS: COB	13,148.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,499,772.16

TOTAL NUMBER OF ADMISSIONS 187

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	663	0	393,822.00	18,182.00
ROUTINE NURSERY	56	0	20,548.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	719	0	414,370.00	18,182.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	173	0	249,700.00	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	173	0	249,700.00	0.00
TOTAL ACCOMODATIONS	892	0	664,070.00	18,182.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,183,521.88	0.00	OTHER LAB	14,505.00	0.00
MED/SURG SUPPLY	843,927.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	500,462.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,720.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	278,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,179.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,962.00	0.00	MRI SERVICES	20,220.00	0.00
IV THERAPY	66,750.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	640,686.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,972.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	245,968.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,990.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,423.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,007.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,652.00	0.00	INJECTABLE DRUGS	4,758.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,256.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,593.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,580.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,426.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	382,955.00	0.00
LITHOTRIPSY	22,298.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,460.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,847.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,452.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,766.00	0.00			
AMBULATORY SURGERY	8,602.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,541.64	0.00			

TOTAL ANCILLARY	4,819,392.83	5,426.00
TOTAL ACCOMODATIONS	664,070.00	18,182.00
TOTAL CHARGES	5,483,462.83	23,608.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	120,976.00	ADJUSTMENTS	0.00
COVERED CHARGES	120,612.00	CONTRACTUAL ALLOW	54,545.49
NON-COVERD CHARGES	364.00	TOTAL MEDICAID LIAB	66,066.51
		LESS: COB	66,066.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13	0	7,722.00	364.00
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	7,722.00	364.00
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	7,722.00	364.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,720.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,364.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,437.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,126.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,049.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	965.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,542.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	171.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,468.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	670.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.00	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	1,982.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	112,890.00	0.00
TOTAL ACCOMODATIONS	7,722.00	364.00
TOTAL CHARGES	120,612.00	364.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	4,628,191.35	ADJUSTMENTS	332,282.42
COVERED CHARGES	4,081,399.69	CONTRACTUAL ALLOW	3,274,185.08
NON-COVERD CHARGES	546,791.66	TOTAL MEDICAID LIAB	807,214.61
		LESS: COB	1,340.25
		LESS: COPAYMENT	2,128.30
		REIMBURSEMENT	803,746.06
		ALL OTHER	726,819.78
		FEE SCHEDULE-LAB	66,629.13
		INJECTABLE DRUGS	10,297.15

TOTAL NUMBER OF CLAIMS 2,042

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253,868.04	7,940.99	OTHER LAB	18,352.00	0.00
MED/SURG SUPPLY	489,565.55	1,251.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161,733.00	4,861.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	597,201.00	159,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,281.00	3,852.00	FEE SCHEDULE LAB	536,331.00	56,490.00
EKG/ECG	50,182.00	5,054.00	MRI SERVICES	88,933.00	0.00
IV THERAPY	124,538.00	66,655.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	267,764.00	56,582.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,616.00	1,236.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,733.00	16,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,744.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	599,592.00	5,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,810.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	135,333.25	68,185.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	548.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,332.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,217.00	306.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,377.00	34,974.00
LITHOTRIPSY	194,693.00	594.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	84,877.00	11,564.00			
BLOOD	2,091.00	0.00			
BLOOD STORAGE & PRO.	9,927.00	3,485.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,302.00	9,339.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,658.00	9,797.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,680.85	21,593.00			

TOTAL ANCILLARY	4,081,399.69	546,791.66
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,081,399.69	546,791.66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	149,053.05	ADJUSTMENTS	0.00
COVERED CHARGES	102,481.05	CONTRACTUAL ALLOW	35,813.58
NON-COVERD CHARGES	46,572.00	TOTAL MEDICAID LIAB	66,667.47
		LESS: COB	66,659.31
		LESS: COPAYMENT	8.16
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 49

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,218.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,610.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,924.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,297.00	13,315.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	340.00	FEE SCHEDULE LAB	14,945.00	3,092.00
EKG/ECG	875.00	0.00	MRI SERVICES	3,646.00	15,148.00
IV THERAPY	5,951.00	3,160.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,322.00	3,346.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,710.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	348.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,092.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,276.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,050.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,820.00	3,375.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	533.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	303.00
LITHOTRIPSY	11,149.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,588.00	1,961.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,999.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,659.98	0.00			

TOTAL ANCILLARY	102,481.05	46,572.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	102,481.05	46,572.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	806,054.35	ADJUSTMENTS	4,189.32
COVERED CHARGES	693,592.35	CONTRACTUAL ALLOW	662,210.01
NON-COVERD CHARGES	112,462.00	TOTAL MEDICAID LIAB	31,382.34
		LESS: COB	0.00
		LESS: COPAYMENT	1,194.00
		REIMBURSEMENT	30,188.34
		TOTAL NUMBER OF CLAIMS	561

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,328.00	170.00	OTHER LAB	5,510.00	0.00
MED/SURG SUPPLY	36,355.56	529.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,342.00	2,768.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	143,934.00	64,964.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	539.00	FEE SCHEDULE LAB	90,846.00	10,300.00
EKG/ECG	10,661.00	175.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,690.00	12,902.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,310.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	695.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,020.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260,922.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	450.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,918.09	16,192.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	156.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,257.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,097.00	3,226.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	697.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,100.70	0.00			

TOTAL ANCILLARY	693,592.35	112,462.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	693,592.35	112,462.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,571.58	ADJUSTMENTS	0.00
COVERED CHARGES	40,199.58	CONTRACTUAL ALLOW	18,367.69
NON-COVERD CHARGES	9,372.00	TOTAL MEDICAID LIAB	21,831.89
		LESS: COB	21,807.89
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,432.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,727.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	950.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,248.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,465.00	648.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,354.00	173.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,536.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	516.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	912.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,306.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,399.00	303.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,257.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	845.44	0.00			

TOTAL ANCILLARY	40,199.58	9,372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,199.58	9,372.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	526,908.35	ADJUSTMENTS	58,761.30
COVERED CHARGES	474,559.35	CONTRACTUAL ALLOW	392,213.73
NON-COVERD CHARGES	52,349.00	TOTAL MEDICAID LIAB	82,345.62
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	82,270.62

TOTAL NUMBER OF CLAIMS 14

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,301.00	368.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	88,538.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,106.00	842.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	736.00	FEE SCHEDULE LAB	6,509.00	526.00
EKG/ECG	1,743.00	350.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	303.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,091.00	3,268.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,239.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,297.00	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	8,318.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,677.07	3,260.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	644.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,756.00	42,696.00
LITHOTRIPSY	135,242.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,098.00	0.00			

TOTAL ANCILLARY	474,559.35	52,349.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	474,559.35	52,349.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	268,317.47	ADJUSTMENTS	0.00
COVERED CHARGES	264,406.47	CONTRACTUAL ALLOW	162,609.29
NON-COVERD CHARGES	3,911.00	TOTAL MEDICAID LIAB	101,797.18
		LESS: COB	2,698.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,099.18

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	66	0	39,348.00	3,138.00
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	66	0	39,348.00	3,138.00
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	66	0	39,348.00	3,138.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,299.61	0.00	OTHER LAB	765.00	0.00
MED/SURG SUPPLY	22,836.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,476.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,336.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,032.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,044.00	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	837.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,320.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	884.00	773.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,228.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	225,058.47	773.00
TOTAL ACCOMODATIONS	39,348.00	3,138.00
TOTAL CHARGES	264,406.47	3,911.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,664,991.82	ADJUSTMENTS	100,792.38
COVERED CHARGES	1,545,317.70	CONTRACTUAL ALLOW	1,067,802.44
NON-COVERD CHARGES	119,674.12	TOTAL MEDICAID LIAB	477,515.26
		LESS: COB	0.00
		LESS: COPAYMENT	470.62
		REIMBURSEMENT	477,044.64
		ALL OTHER	433,781.32
		FEE SCHEDULE-LAB	39,204.90
		INJECTABLE DRUGS	4,058.42

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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,367.14	437.97	OTHER LAB	3,060.00	0.00
MED/SURG SUPPLY	31,808.85	363.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,789.00	1,795.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	309,436.00	39,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,378.00	880.00	FEE SCHEDULE LAB	385,943.50	25,856.00
EKG/ECG	25,144.00	2,536.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,760.00	10,780.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,304.00	8,110.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,780.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	479,789.00	9,397.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	76,632.21	13,602.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,478.46
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,478.00	1,279.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,069.00	773.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,456.00	2,614.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,306.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,817.00	356.00			

TOTAL ANCILLARY	1,545,317.70	119,674.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,545,317.70	119,674.12

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	18,125.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,554.00	CONTRACTUAL ALLOW	4,430.63
NON-COVERD CHARGES	2,571.00	TOTAL MEDICAID LIAB	11,123.37
		LESS: COB	11,120.37
		LESS: COPAYMENT	3.00
		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 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 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	288.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,575.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,115.00	198.00
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	537.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	798.00	798.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,816.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	15,554.00	2,571.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,554.00	2,571.00

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	58,511.97	ADJUSTMENTS	117.00
COVERED CHARGES	55,131.80	CONTRACTUAL ALLOW	52,461.80
NON-COVERD CHARGES	3,380.17	TOTAL MEDICAID LIAB	2,670.00
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	2,589.00
		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

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,409.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	722.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,216.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,439.00	1,575.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,099.00	770.00
EKG/ECG	804.00	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	72.00	244.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	108.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,859.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,403.43	791.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,131.80	3,380.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,131.80	3,380.17

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE 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 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/17 THROUGH 07/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,141,217.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,131,792.94	CONTRACTUAL ALLOW	1,644,013.33
NON-COVERD CHARGES	9,424.14	TOTAL MEDICAID LIAB	487,779.61
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	487,779.61

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	20	0	13,872.63	998.55
ROUTINE NURSERY	11	0	4,074.73	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	17,947.36	998.55
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	122	0	204,197.26	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	122	0	204,197.26	0.00
TOTAL ACCOMODATIONS	153	0	222,144.62	998.55

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	333,960.88	0.00	OTHER LAB	17,208.14	0.00
MED/SURG SUPPLY	57,500.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	229,514.03	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,605.71	0.00	OTHER THERAPEUTIC SVC	0.00	550.36
CT SCAN	112,899.07	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,785.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,031.79	0.00	MRI SERVICES	30,185.12	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	246,059.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	299,869.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	171,653.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,666.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107,147.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,928.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	956.11	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,804.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,711.98	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	960.65	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	584.32	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,790.83	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,673.38	0.00			
BLOOD	7,274.88	0.00			
BLOOD STORAGE & PRO.	8,901.98	7,713.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,293.89	162.11			
AUDIOLOGY	746.68	0.00			
CARDIOLOGY	68,933.79	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,909,648.32	8,425.59
TOTAL ACCOMODATIONS	222,144.62	998.55
TOTAL CHARGES	2,131,792.94	9,424.14

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,436,091.50	ADJUSTMENTS	38,363.69
COVERED CHARGES	1,809,170.51	CONTRACTUAL ALLOW	1,595,707.18
NON-COVERD CHARGES	626,920.99	TOTAL MEDICAID LIAB	213,463.33
		LESS: COB	0.00
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	213,031.33
		ALL OTHER	192,272.03
		FEE SCHEDULE-LAB	17,838.30
		INJECTABLE DRUGS	2,921.00

TOTAL NUMBER OF CLAIMS 571

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,771.20	40,152.79	OTHER LAB	30,711.94	0.00
MED/SURG SUPPLY	18,416.26	666.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,886.46	39,515.28	OTHER THERAPEUTIC SVC	0.00	8,264.30
CT SCAN	102,352.00	235,182.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	777.28	FEE SCHEDULE LAB	316,919.47	27,831.15
EKG/ECG	55,384.49	635.37	MRI SERVICES	5,543.98	10,284.40
IV THERAPY	8,242.57	2,769.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,773.92	36,709.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,251.27	9,158.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,525.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,240.49	21,298.44	CAST ROOM	0.00	0.00
EMERGENCY ROOM	815,625.15	59,223.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,959.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,899.15	9,509.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	842.58	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,340.28	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	854.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	732.18	9,201.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,915.11	3,324.16			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,343.46	1,928.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,899.35	34,803.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,379.57	68,933.79			
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	99,396.86	3,714.67			

TOTAL ANCILLARY	1,809,170.51	626,920.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,809,170.51	626,920.99

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	216,252.91	ADJUSTMENTS	1,279.56
COVERED CHARGES	181,307.07	CONTRACTUAL ALLOW	176,943.75
NON-COVERD CHARGES	34,945.84	TOTAL MEDICAID LIAB	4,363.32
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	4,174.32
		TOTAL NUMBER OF CLAIMS	78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,482.20	2,370.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	276.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,440.60	5,822.81	OTHER THERAPEUTIC SVC	0.00	275.18
CT SCAN	4,373.04	23,450.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,371.26	1,819.03
EKG/ECG	6,353.70	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	933.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,171.49	552.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,905.09	207.50
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	447.76			

TOTAL ANCILLARY	181,307.07	34,945.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	181,307.07	34,945.84

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	174,009.69	ADJUSTMENTS	0.00
COVERED CHARGES	172,972.07	CONTRACTUAL ALLOW	156,650.27
NON-COVERD CHARGES	1,037.62	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	16,312.80

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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338.84	751.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,844.75	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	1,995.26	31.11
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,776.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,657.22	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	10,569.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,940.95	255.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,030.06	0.00
LITHOTRIPSY	54,819.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	172,972.07	1,037.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	172,972.07	1,037.62

GEORGIA DEPARTMENT OF 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 04/01/18 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,711,910.28	ADJUSTMENTS	57,952.82
COVERED CHARGES	3,691,764.74	CONTRACTUAL ALLOW	2,908,905.10
NON-COVERD CHARGES	20,145.54	TOTAL MEDICAID LIAB	782,859.64
		LESS: COB	941.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	781,917.90

TOTAL NUMBER OF ADMISSIONS 89

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	102	0	72,666.99	5,858.16
ROUTINE NURSERY	30	0	11,112.90	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	132	0	83,779.89	5,858.16
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	186	0	270,839.44	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	186	0	270,839.44	0.00
TOTAL ACCOMODATIONS	318	0	354,619.33	5,858.16

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512,561.67	0.00	OTHER LAB	40,035.49	0.00
MED/SURG SUPPLY	83,238.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	563,217.36	0.00	EDUCATION & TRAINING	244.27	0.00
RADIOLOGY-DIAGNOSTIC	118,052.64	0.00	OTHER THERAPEUTIC SVC	0.00	4,645.98
CT SCAN	250,228.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,597.37	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	49,805.65	0.00	MRI SERVICES	62,273.31	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	281,898.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,225.22	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	430,531.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	183,892.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,603.49	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	302,394.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,199.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,899.58	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,460.37	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,558.97	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,645.85	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,752.96	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,807.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,851.42	0.00			
BLOOD	1,818.72	0.00			
BLOOD STORAGE & PRO.	10,628.57	9,641.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,426.71	0.00			
CARDIOLOGY	217,296.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	3,337,145.41	14,287.38
TOTAL ACCOMODATIONS	354,619.33	5,858.16
TOTAL CHARGES	3,691,764.74	20,145.54

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	7,126.01	ADJUSTMENTS	0.00
COVERED CHARGES	7,126.01	CONTRACTUAL ALLOW	806.57
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,319.44
		LESS: COB	6,319.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	644.04	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	1	0	644.04	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	1	0	644.04	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,019.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,624.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,741.74	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.68	0.00	FREE STANDING CLINIC	0.00	0.00
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	6,481.97	0.00
TOTAL ACCOMODATIONS	644.04	0.00
TOTAL CHARGES	7,126.01	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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,189,952.25	ADJUSTMENTS	209,914.68
COVERED CHARGES	5,767,868.47	CONTRACTUAL ALLOW	5,350,545.27
NON-COVERD CHARGES	422,083.78	TOTAL MEDICAID LIAB	417,323.20
		LESS: COB	620.83
		LESS: COPAYMENT	1,047.00
		REIMBURSEMENT	415,655.37
		ALL OTHER	362,557.21
		FEE SCHEDULE-LAB	46,911.60
		INJECTABLE DRUGS	6,186.56

TOTAL NUMBER OF CLAIMS 1,494

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153,919.61	3,904.39	OTHER LAB	44,784.06	0.00
MED/SURG SUPPLY	62,099.95	2,452.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	82.02
RADIOLOGY-DIAGNOSTIC	305,354.27	4,137.86	OTHER THERAPEUTIC SVC	0.00	34,884.76
CT SCAN	626,042.96	126,306.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,472.00	2,250.96	FEE SCHEDULE LAB	717,448.45	26,564.66
EKG/ECG	135,451.84	635.37	MRI SERVICES	46,648.53	0.00
IV THERAPY	6,886.65	2,643.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	333,128.14	21,231.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	204.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,136.04	19,195.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	151,056.55	7,719.88	AMBULANCE	0.00	0.00
GI SERVICES	51,849.72	1,186.01	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,292,253.04	32,589.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	146,644.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	152,716.17	42,108.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	706.64	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,365.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,020.84	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.16	4,838.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,147.81	1,171.36
LITHOTRIPSY	54,819.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,050.00	5,950.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,878.88	1,928.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,544.30	30,715.34			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,335.43	30,637.24			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154,893.86	12,857.82			

TOTAL ANCILLARY	5,767,868.47	422,083.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,767,868.47	422,083.78

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 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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,418.03	ADJUSTMENTS	0.00
COVERED CHARGES	115,626.34	CONTRACTUAL ALLOW	65,109.68
NON-COVERD CHARGES	68,791.69	TOTAL MEDICAID LIAB	50,516.66
		LESS: COB	50,510.66
		LESS: COPAYMENT	6.00
		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

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697.12	8,146.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,455.38	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,014.70	2,044.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,707.33	4,075.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,141.38	251.80
EKG/ECG	635.37	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,347.61	22,945.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	889.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,684.70	14,268.19	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,187.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,394.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,977.20	367.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	142.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	16,362.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,493.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	115,626.34	68,791.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,626.34	68,791.69

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	729,525.02	ADJUSTMENTS	644.28
COVERED CHARGES	692,714.43	CONTRACTUAL ALLOW	678,488.11
NON-COVERD CHARGES	36,810.59	TOTAL MEDICAID LIAB	14,226.32
		LESS: COB	28.18
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	13,709.14
		TOTAL NUMBER OF CLAIMS	263

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,249.99	1,040.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	829.02	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,360.68	6,852.05	OTHER THERAPEUTIC SVC	0.00	2,751.80
CT SCAN	60,751.27	16,934.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,633.77	3,336.75
EKG/ECG	24,779.43	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	6,394.18	1,866.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	441,027.56	2,218.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,323.77	829.07
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,364.76	793.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	692,714.43	36,810.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	692,714.43	36,810.59

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	29,426.49	ADJUSTMENTS	0.00
COVERED CHARGES	24,240.90	CONTRACTUAL ALLOW	12,937.24
NON-COVERD CHARGES	5,185.59	TOTAL MEDICAID LIAB	11,303.66
		LESS: COB	11,294.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.70	13.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	753.72	0.00	OTHER THERAPEUTIC SVC	0.00	275.18
CT SCAN	0.00	4,707.33	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,050.86	189.58
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	17,349.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,060.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	24,240.90	5,185.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,240.90	5,185.59

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

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HIGHWAY 5
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,433,143.28	ADJUSTMENTS	17,158.91
COVERED CHARGES	2,427,529.51	CONTRACTUAL ALLOW	2,083,662.46
NON-COVERD CHARGES	5,613.77	TOTAL MEDICAID LIAB	343,867.05
		LESS: COB	1,611.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	342,255.14

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	91,537.80	2,307.81
ROUTINE NURSERY	13	0	10,123.74	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	96	0	101,661.54	2,307.81
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	34	0	52,749.88	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	34	0	52,749.88	0.00
TOTAL ACCOMODATIONS	130	0	154,411.42	2,307.81

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218,318.86	0.00	OTHER LAB	3,392.35	0.00
MED/SURG SUPPLY	63,538.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	355,376.39	0.00	EDUCATION & TRAINING	186.02	0.00
RADIOLOGY-DIAGNOSTIC	14,845.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	82,486.83	1,914.43	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,796.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,504.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,260.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	628,864.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,724.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,034.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,004.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,275.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,264.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,633.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	16,146.71	0.00	INJECTABLE DRUGS	424,391.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,988.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,185.35	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,220.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,559.47	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,908.14	1,135.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,046.28	255.65			
AUDIOLOGY	1,415.70	0.00			
CARDIOLOGY	11,068.50	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	5,680.74	0.00			

TOTAL ANCILLARY	2,273,118.09	3,305.96
TOTAL ACCOMODATIONS	154,411.42	2,307.81
TOTAL CHARGES	2,427,529.51	5,613.77

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	5,686,263.11	ADJUSTMENTS	189,094.65
COVERED CHARGES	5,285,073.33	CONTRACTUAL ALLOW	4,778,822.86
NON-COVERD CHARGES	401,189.78	TOTAL MEDICAID LIAB	506,250.47
		LESS: COB	16.65
		LESS: COPAYMENT	1,767.00
		REIMBURSEMENT	504,466.82
		ALL OTHER	389,513.23
		FEE SCHEDULE-LAB	70,806.56
		INJECTABLE DRUGS	44,147.03

TOTAL NUMBER OF CLAIMS 1,610

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172,362.59	3,345.29	OTHER LAB	172,102.16	3,596.14
MED/SURG SUPPLY	14,431.50	201.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,370.97	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150,661.12	3,014.67	OTHER THERAPEUTIC SVC	0.00	1,429.60
CT SCAN	568,555.14	27,845.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,241.44	10,181.11	FEE SCHEDULE LAB	1,512,948.43	72,812.29
EKG/ECG	57,467.13	1,680.68	MRI SERVICES	223,863.32	5,618.34
IV THERAPY	14,540.40	1,614.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	405,836.28	62,028.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,337.66	0.00	REHAB THERAPY	2,678.76	0.00
RESPIRATORY SERVICES	36,906.17	3,242.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,803.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	172,178.79	42,953.43	CAST ROOM	0.00	0.00
EMERGENCY ROOM	743,299.39	2,815.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	107,770.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	457,576.73	131,532.70
RADIOLOGY THERAPEUTIC	6,538.95	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	464.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,253.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	364.94	582.56	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,137.20	386.45
LITHOTRIPSY	70,416.21	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,996.10	2,335.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	52,093.19	10,279.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	81,829.14	11,068.50			
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	28,672.34	0.00			

TOTAL ANCILLARY	5,285,073.33	401,189.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,285,073.33	401,189.78

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	21,786.67	ADJUSTMENTS	0.00
COVERED CHARGES	20,677.00	CONTRACTUAL ALLOW	9,408.83
NON-COVERD CHARGES	1,109.67	TOTAL MEDICAID LIAB	11,268.17
		LESS: COB	11,265.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,123.68	186.02	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	6,956.13	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,484.72	167.78
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,168.83	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	4,750.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,979.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	145.64	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	610.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,213.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	20,677.00	1,109.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,677.00	1,109.67

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	178,901.65	ADJUSTMENTS	1,217.92
COVERED CHARGES	173,735.56	CONTRACTUAL ALLOW	170,759.46
NON-COVERD CHARGES	5,166.09	TOTAL MEDICAID LIAB	2,976.10
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	2,919.10
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,365.18	27.49	OTHER LAB	1,966.16	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	3,949.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,657.62	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,732.84	2,138.83
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,876.99	117.18	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,985.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,338.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,096.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,783.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,857.37	1,899.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,849.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,396.84	983.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,054.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	825.41	0.00			

TOTAL ANCILLARY	173,735.56	5,166.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	173,735.56	5,166.09

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	682,502.51	ADJUSTMENTS	49,178.34
COVERED CHARGES	670,249.01	CONTRACTUAL ALLOW	621,043.67
NON-COVERD CHARGES	12,253.50	TOTAL MEDICAID LIAB	49,205.34
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	49,178.34
		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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,764.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,933.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,074.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,842.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,571.82	210.92
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	604.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	440,744.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	289.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,396.09	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,125.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,224.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,381.72	11,269.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	15,790.26	772.90
LITHOTRIPSY	23,472.07	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,033.49	0.00			

TOTAL ANCILLARY	670,249.01	12,253.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	670,249.01	12,253.50

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

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	8,739,754.00	ADJUSTMENTS	40,644.82
COVERED CHARGES	8,445,435.00	CONTRACTUAL ALLOW	3,436,136.70
NON-COVERD CHARGES	294,319.00	TOTAL MEDICAID LIAB	5,009,298.30
		LESS: COB	774.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,008,523.42

TOTAL NUMBER OF ADMISSIONS 1,226

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,547	0	3,882,900.00	273,000.00
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	5,547	0	3,882,900.00	273,000.00
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	5,547	0	3,882,900.00	273,000.00

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,708,441.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	792,477.00	635.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,916.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,908.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,772.00	0.00	MRI SERVICES	5,470.00	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	247.00	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	180.00	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	NO CC/INVALID REV CODE	0.00	20,684.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124.00	0.00			

TOTAL ANCILLARY	4,562,535.00	21,319.00
TOTAL ACCOMODATIONS	3,882,900.00	273,000.00
TOTAL CHARGES	8,445,435.00	294,319.00

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 01/01/18 THROUGH 12/31/18
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
25	2218040008770	01/30/18 - 02/05/18	02/12/18	0.00	2,549.00	0.00	0.00	0.00
3001	2218082007692	03/16/18 - 03/19/18	03/26/18	0.00	194.00	0.00	0.00	0.00
3001	2218082009201	03/15/18 - 03/19/18	03/26/18	0.00	316.00	0.00	0.00	0.00
25	2218089006383	03/18/18 - 03/26/18	04/02/18	0.00	4,383.00	0.00	0.00	0.00
25	2218145006657	05/15/18 - 05/21/18	05/28/18	0.00	3,591.00	0.00	0.00	0.00
780	2218164000669	05/18/18 - 05/22/18	06/18/18	0.00	34.00	0.00	0.00	0.00
3901	2218183006165	06/23/18 - 06/26/18	07/09/18	0.00	378.00	0.00	0.00	0.00
2501	2218304013734	10/18/18 - 10/24/18	11/05/18	0.00	8,861.00	0.00	0.00	0.00
3011	2219002002957	12/22/18 - 12/26/18	01/07/19	0.00	378.00	0.00	0.00	0.00
TOTAL				0.00	20,684.00	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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	56,268.00	ADJUSTMENTS	246.46
COVERED CHARGES	55,930.00	CONTRACTUAL ALLOW	37,409.16
NON-COVERD CHARGES	338.00	TOTAL MEDICAID LIAB	18,520.84
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	18,346.84
		ALL OTHER	18,346.84
		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 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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 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	17,344.00	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	27,248.00	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	338.00
EKG/ECG	247.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,091.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	55,930.00	338.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,930.00	338.00

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 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/18 THROUGH 12/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	49,743,633.89	ADJUSTMENTS	1,463,301.92
COVERED CHARGES	48,068,389.46	CONTRACTUAL ALLOW	37,449,185.86
NON-COVERD CHARGES	1,675,244.43	TOTAL MEDICAID LIAB	10,619,203.60
		LESS: COB	81,871.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,537,332.41

TOTAL NUMBER OF ADMISSIONS 1,207

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,935	0	4,070,718.00	565,554.00
ROUTINE NURSERY	1,163	0	1,960,776.00	427,977.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	2.00
TOTAL ROUTINE	5,098	0	6,031,494.00	993,533.00
SPECIAL CARE SERVICES				
CCU	607	0	1,937,596.00	0.00
ICU	446	0	1,423,216.00	0.00
NICU	76	0	302,236.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,129	0	3,663,048.00	0.00
TOTAL ACCOMODATIONS	6,227	0	9,694,542.00	993,533.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,505,876.78	26,382.17	OTHER LAB	468,984.00	815.00
MED/SURG SUPPLY	973,102.86	11,588.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,009,130.40	118,518.00	EDUCATION & TRAINING	8,820.00	136.00
RADIOLOGY-DIAGNOSTIC	889,705.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,444,027.00	12,180.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	384,068.11	10,092.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	314,496.00	0.00	MRI SERVICES	582,426.00	3,383.00
IV THERAPY	39,753.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,987,340.00	44,387.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,467,004.00	182,126.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,282,798.00	25,835.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	470,367.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	482,972.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,789,897.00	4,380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	593,624.00	3,427.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	251,880.00	482.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	59,156.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	233,340.77	7,742.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	131,962.60	614.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,013,711.00	78,418.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,224.00	18,419.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	877,121.34	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	434,657.00	5,416.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	524,482.00	69,546.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	234,835.00	57,345.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,413,622.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	127,922.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	365,542.60	480.00			

TOTAL ANCILLARY	38,373,847.46	681,711.43
TOTAL ACCOMODATIONS	9,694,542.00	993,533.00
TOTAL CHARGES	48,068,389.46	1,675,244.43

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	184,708.17	ADJUSTMENTS	0.00
COVERED CHARGES	179,753.17	CONTRACTUAL ALLOW	104,054.98
NON-COVERD CHARGES	4,955.00	TOTAL MEDICAID LIAB	75,698.19
		LESS: COB	75,698.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	20	0	21,120.00	4,387.00
ROUTINE NURSERY	11	0	17,349.00	568.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	31	0	38,469.00	4,955.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1	0	3,151.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	3,151.00	0.00
TOTAL ACCOMODATIONS	32	0	41,620.00	4,955.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,092.35	0.00	OTHER LAB	1,887.00	0.00
MED/SURG SUPPLY	1,443.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,034.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,656.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,048.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	832.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,695.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,472.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,232.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,117.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,970.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,446.00	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	203.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,364.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,824.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,284.00	0.00			

TOTAL ANCILLARY	138,133.17	0.00
TOTAL ACCOMODATIONS	41,620.00	4,955.00
TOTAL CHARGES	179,753.17	4,955.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,296,395.95	ADJUSTMENTS	383,512.21
COVERED CHARGES	19,616,650.58	CONTRACTUAL ALLOW	17,355,349.76
NON-COVERD CHARGES	4,679,745.37	TOTAL MEDICAID LIAB	2,261,300.82
		LESS: COB	59,660.26
		LESS: COPAYMENT	3,862.28
		REIMBURSEMENT	2,197,778.28
		ALL OTHER	1,959,760.86
		FEE SCHEDULE-LAB	194,669.85
		INJECTABLE DRUGS	43,347.57

TOTAL NUMBER OF CLAIMS 5,121

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325,434.20	0.00	OTHER LAB	399,727.00	4,441.00
MED/SURG SUPPLY	352,856.63	80,024.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	40.00	EDUCATION & TRAINING	0.00	408.00
RADIOLOGY-DIAGNOSTIC	993,884.00	180,263.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,063,588.00	729,356.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,747.00	23,262.13	FEE SCHEDULE LAB	3,041,272.50	169,884.00
EKG/ECG	352,352.00	5,824.00	MRI SERVICES	186,949.00	147,995.00
IV THERAPY	44,366.00	744.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,022,886.00	387,951.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	140,903.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,733.00	24,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	232,444.00	3,616.00	AMBULANCE	0.00	0.00
GI SERVICES	182,168.00	106,800.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,290,175.00	178,625.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	308,417.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	455,308.27	491,979.03
RADIOLOGY THERAPEUTIC	184,942.00	226,436.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	53,394.00	30,753.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,632.00	18,150.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	66,216.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	93,070.00	17,894.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	137,576.74	534,544.31
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	639,891.00	207,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	87,833.00	63,274.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	119,151.00	217,940.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	294,243.00	735,473.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	72,588.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	391,119.24	25,853.00			

TOTAL ANCILLARY	19,616,650.58	4,679,745.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,616,650.58	4,679,745.37

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	397,767.15	ADJUSTMENTS	0.00
COVERED CHARGES	295,302.88	CONTRACTUAL ALLOW	212,189.39
NON-COVERD CHARGES	102,464.27	TOTAL MEDICAID LIAB	83,113.49
		LESS: COB	83,097.85
		LESS: COPAYMENT	15.64
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,103.18	0.00	OTHER LAB	3,774.00	0.00
MED/SURG SUPPLY	12,668.08	394.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,373.00	1,773.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,088.00	16,290.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,022.00	3,294.00
EKG/ECG	2,912.00	416.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,179.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,754.00	46,602.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,883.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,067.00	4,417.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,477.00	3,820.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,252.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,157.17	3,887.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	142.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,809.45	262.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,986.00	9,892.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	11,416.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,462.00	0.00			

TOTAL ANCILLARY	295,302.88	102,464.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	295,302.88	102,464.27

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	780,128.67	ADJUSTMENTS	329.64
COVERED CHARGES	708,119.00	CONTRACTUAL ALLOW	689,714.74
NON-COVERD CHARGES	72,009.67	TOTAL MEDICAID LIAB	18,404.26
		LESS: COB	0.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	17,885.26
		TOTAL NUMBER OF CLAIMS	329

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,051.58	166.40	OTHER LAB	5,661.00	0.00
MED/SURG SUPPLY	5,817.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,583.00	8,920.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,122.00	22,718.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	123,079.00	5,697.00
EKG/ECG	6,240.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,974.00	14,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	351.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,016.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,337.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	410,982.00	4,185.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,234.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,785.91	2,208.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,759.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,980.00	9,246.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,587.00	1,861.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,318.40	0.00			

TOTAL ANCILLARY	708,119.00	72,009.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	708,119.00	72,009.67

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,230.33	ADJUSTMENTS	0.00
COVERED CHARGES	22,753.73	CONTRACTUAL ALLOW	17,914.01
NON-COVERD CHARGES	3,476.60	TOTAL MEDICAID LIAB	4,839.72
		LESS: COB	4,818.72
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	357.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,286.00	598.00
EKG/ECG	416.00	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	15,922.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.69	15.60
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,753.73	3,476.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,753.73	3,476.60

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	967,334.12	ADJUSTMENTS	21,723.40
COVERED CHARGES	783,387.71	CONTRACTUAL ALLOW	728,719.21
NON-COVERD CHARGES	183,946.41	TOTAL MEDICAID LIAB	54,668.50
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	54,608.50
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,463.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,321.14	1,565.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,134.00	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	3,524.00	368.00
EKG/ECG	832.00	416.00	MRI SERVICES	0.00	0.00
IV THERAPY	449.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	140,964.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	580.00	614.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,736.00	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	6,084.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	477,596.31	30,486.79
RADIOLOGY THERAPEUTIC	8,940.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	96,262.24	81,162.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	69,030.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,502.00	304.00			

TOTAL ANCILLARY	783,387.71	183,946.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	783,387.71	183,946.41

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 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	75,322.16	ADJUSTMENTS	0.00
COVERED CHARGES	51,674.07	CONTRACTUAL ALLOW	44,220.62
NON-COVERD CHARGES	23,648.09	TOTAL MEDICAID LIAB	7,453.45
		LESS: COB	7,450.45
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,369.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	880.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	794.00	40.00
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	13,076.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,028.00	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	3,617.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	418.92	164.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,543.78	7,904.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,440.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	51,674.07	23,648.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,674.07	23,648.09

** 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,876,841.78	ADJUSTMENTS	1,322,485.20
COVERED CHARGES	63,104,843.87	CONTRACTUAL ALLOW	53,126,543.42
NON-COVERD CHARGES	11,771,997.91	TOTAL MEDICAID LIAB	9,978,300.45
		LESS: COB	105,265.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,873,035.10

TOTAL NUMBER OF ADMISSIONS 1,234

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	7,455	0	11,409,393.83	11,173,085.88
ROUTINE NURSERY	454	0	757,357.96	123,857.80
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,909	0	12,166,751.79	11,296,943.68
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,251	0	3,985,495.51	16,714.49
NICU	6	0	25,540.38	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,257	0	4,011,035.89	16,714.49
TOTAL ACCOMODATIONS	9,166	0	16,177,787.68	11,313,658.17

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,832,692.81	24,229.26	OTHER LAB	305,873.31	0.00
MED/SURG SUPPLY	2,269,553.05	12,878.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,553,936.43	46,188.12	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	841,118.95	6,171.61	OTHER THERAPEUTIC SVC	0.00	3,622.50
CT SCAN	2,854,590.49	56,778.91	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	663,053.46	27,474.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	688,502.55	799.17	MRI SERVICES	583,751.49	0.00
IV THERAPY	1,513.59	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,418,158.54	70,516.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	519,339.39	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,075,485.84	38,769.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	664,019.41	3,367.79	AMBULANCE	0.00	0.00
GI SERVICES	506,141.46	13,332.77	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,441,634.37	9,086.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	533,173.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,259.93
LABORATORY PATHOLOGIC	263,717.31	0.00	INJECTABLE DRUGS	6,535,464.35	19,145.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	490,275.34	14,622.48	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	369,908.97	33,043.54	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	372,404.74	1,925.09	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,951.19	612.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	54,992.20	0.00	IMPL DEV CHARGE PATIENTS	1,434,197.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	252,999.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	149,890.93	66,264.29			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	805,317.58	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,151,620.24	5,251.53			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,587.41	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	168,190.13	0.00			

TOTAL ANCILLARY	46,927,056.19	458,339.74
TOTAL ACCOMODATIONS	16,177,787.68	11,313,658.17
TOTAL CHARGES	63,104,843.87	11,771,997.91

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	55,904.35	ADJUSTMENTS	0.00
COVERED CHARGES	55,532.38	CONTRACTUAL ALLOW	41,353.37
NON-COVERD CHARGES	371.97	TOTAL MEDICAID LIAB	14,179.01
		LESS: COB	14,179.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	4,605.00	371.97
ROUTINE NURSERY	8	0	6,795.52	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	11,400.52	371.97
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	11,400.52	371.97

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,243.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	205.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,459.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	857.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,993.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	799.17	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,901.28	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	372.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	916.93	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,687.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	446.99	0.00	INJECTABLE DRUGS	5,960.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	288.27	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	44,131.86	0.00
TOTAL ACCOMODATIONS	11,400.52	371.97
TOTAL CHARGES	55,532.38	371.97

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,768,620.04	ADJUSTMENTS	120,106.94
COVERED CHARGES	17,413,804.34	CONTRACTUAL ALLOW	16,021,550.79
NON-COVERD CHARGES	2,354,815.70	TOTAL MEDICAID LIAB	1,392,253.55
		LESS: COB	6,480.14
		LESS: COPAYMENT	2,654.03
		REIMBURSEMENT	1,383,119.38
		ALL OTHER	1,275,301.59
		FEE SCHEDULE-LAB	92,604.87
		INJECTABLE DRUGS	15,212.92

TOTAL NUMBER OF CLAIMS 3,177

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,096.15	234,550.66	OTHER LAB	163,920.80	0.00
MED/SURG SUPPLY	265,405.50	21,029.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	219.36
RADIOLOGY-DIAGNOSTIC	650,540.24	95,761.60	OTHER THERAPEUTIC SVC	0.00	523.67
CT SCAN	2,192,990.16	277,319.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,459.33	42,011.01	FEE SCHEDULE LAB	3,740,365.26	159,028.19
EKG/ECG	407,576.64	2,279.11	MRI SERVICES	163,757.41	59,182.47
IV THERAPY	819,859.18	46,003.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	569,523.43	239,960.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,510.23	4,529.76	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,874.13	17,447.38	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	329,573.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	100,539.97	30,610.95	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,834,750.38	36,002.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	704,526.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,249.58
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391,929.07	158,659.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,392.31	13,010.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,778.54	10,048.13	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,315.11	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110,042.02	7,542.54	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	92,256.65	0.00	IMPL DEV CHARGE PATIENTS	155,484.25	8,457.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,751.68
OTHER IMAGING SERVICE	296,310.91	242,462.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,670.96	2,209.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	494,774.65	269,541.54			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	184,189.32	223,244.94			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,654.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	264,051.99	129,860.62			

TOTAL ANCILLARY	17,413,804.34	2,354,815.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,413,804.34	2,354,815.70

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 09/01/17 THROUGH 08/31/18
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	2218235001394	02/01/18 - 02/01/18	08/27/18	0.00	4,751.68	0.00	0.00	0.00
TOTAL				0.00	4,751.68	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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	428,099.39	ADJUSTMENTS	0.00
COVERED CHARGES	343,622.87	CONTRACTUAL ALLOW	271,769.63
NON-COVERD CHARGES	84,476.52	TOTAL MEDICAID LIAB	71,853.24
		LESS: COB	71,801.16
		LESS: COPAYMENT	52.08
		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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,567.87	2,885.99	OTHER LAB	2,590.70	0.00
MED/SURG SUPPLY	22,165.50	6,946.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,905.93	1,599.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,658.34	7,692.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,894.68	1,365.98
EKG/ECG	5,534.99	0.00	MRI SERVICES	5,548.59	0.00
IV THERAPY	11,846.74	548.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,011.08	40,891.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,792.74	1,221.36	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,450.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,789.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,788.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,091.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,828.47	1,761.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	360.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,741.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,492.27	9,362.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,178.81			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,992.71			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,562.18	5,029.60			

TOTAL ANCILLARY	343,622.87	84,476.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	343,622.87	84,476.52

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,537,594.87	ADJUSTMENTS	4,898.37
COVERED CHARGES	1,420,716.64	CONTRACTUAL ALLOW	1,398,407.61
NON-COVERD CHARGES	116,878.23	TOTAL MEDICAID LIAB	22,309.03
		LESS: COB	0.00
		LESS: COPAYMENT	639.00
		REIMBURSEMENT	21,670.03
		TOTAL NUMBER OF CLAIMS	383

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,108.71	13,777.00	OTHER LAB	8,861.39	0.00
MED/SURG SUPPLY	1,414.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,230.58	12,285.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	95,760.97	34,690.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	927.77	FEE SCHEDULE LAB	400,950.64	8,646.36
EKG/ECG	31,049.23	0.00	MRI SERVICES	0.00	10,494.78
IV THERAPY	61,047.23	806.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,005.31	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	720,499.92	1,131.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,933.98	15,964.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	726.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,389.27	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,205.99	13,795.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,242.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,471.21	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,176.73	0.00			

TOTAL ANCILLARY	1,420,716.64	116,878.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,420,716.64	116,878.23

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,021.67	ADJUSTMENTS	0.00
COVERED CHARGES	40,591.76	CONTRACTUAL ALLOW	27,758.69
NON-COVERD CHARGES	33,429.91	TOTAL MEDICAID LIAB	12,833.07
		LESS: COB	12,821.07
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,048.44	1,846.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	734.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,911.55	15,016.82	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,900.67	10,054.56
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	5,548.59
IV THERAPY	1,370.33	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	22,074.78	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	234.87	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	963.04			
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	1,216.62	0.00			

TOTAL ANCILLARY	40,591.76	33,429.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,591.76	33,429.91

GEORGIA 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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	247,479.66	ADJUSTMENTS	5,559.47
COVERED CHARGES	237,989.16	CONTRACTUAL ALLOW	221,301.75
NON-COVERD CHARGES	9,490.50	TOTAL MEDICAID LIAB	16,687.41
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	16,678.41

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,389.31	3,200.09	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34,313.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	563.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,658.34	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,820.66	467.55
EKG/ECG	799.17	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,097.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,487.91	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	408.49	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,072.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,001.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,625.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,229.98	4,727.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	96.09	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,250.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	999.51			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,432.47	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	2,838.78	0.00			

TOTAL ANCILLARY	237,989.16	9,490.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	237,989.16	9,490.50

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

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 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,269,370.10	ADJUSTMENTS	2,762.25
COVERED CHARGES	1,844,381.10	CONTRACTUAL ALLOW	1,133,800.70
NON-COVERD CHARGES	424,989.00	TOTAL MEDICAID LIAB	710,580.40
		LESS: COB	17,396.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	693,183.99

TOTAL NUMBER OF ADMISSIONS 171

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,033	0	774,750.00	423,617.00
ROUTINE NURSERY	45	0	31,240.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,078	0	805,990.00	423,617.00
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	1,078	0	805,990.00	423,617.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	650,963.00	0.00	OTHER LAB	2,519.00	0.00
MED/SURG SUPPLY	87,717.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	122,831.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,957.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,010.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,688.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,985.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,176.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,913.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,394.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,276.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,228.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	661.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,037.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,915.00	1,372.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	4,640.00	0.00			
CARDIOLOGY	2,048.00	0.00			
AMBULATORY SURGERY	0.00	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			

TOTAL ANCILLARY	1,038,391.10	1,372.00
TOTAL ACCOMODATIONS	805,990.00	423,617.00
TOTAL CHARGES	1,844,381.10	424,989.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,361,357.00	ADJUSTMENTS	437.67
COVERED CHARGES	1,159,665.20	CONTRACTUAL ALLOW	944,083.24
NON-COVERD CHARGES	201,691.80	TOTAL MEDICAID LIAB	215,581.96
		LESS: COB	0.00
		LESS: COPAYMENT	614.89
		REIMBURSEMENT	214,967.07
		ALL OTHER	174,568.85
		FEE SCHEDULE-LAB	40,263.41
		INJECTABLE DRUGS	134.81

TOTAL NUMBER OF CLAIMS 1,012

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	138,829.30	5,835.80	OTHER LAB	4,235.00	0.00
MED/SURG SUPPLY	97,972.50	1,266.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	41.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,954.00	10,849.00	OTHER THERAPEUTIC SVC	0.00	8,625.00
CT SCAN	59,969.00	14,246.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,122.00	4,183.00	FEE SCHEDULE LAB	435,649.40	23,480.00
EKG/ECG	7,700.00	0.00	MRI SERVICES	5,673.00	0.00
IV THERAPY	2,222.00	99,151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,563.00	10,089.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,821.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,378.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,772.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,805.00	1,090.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,705.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,168.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,049.00	5,688.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	870.00	686.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,231.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,405.00	1,024.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,651.00	14,270.00			

TOTAL ANCILLARY	1,159,665.20	201,691.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,159,665.20	201,691.80

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	26,821.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,596.00	CONTRACTUAL ALLOW	6,604.88
NON-COVERD CHARGES	3,225.00	TOTAL MEDICAID LIAB	16,991.12
		LESS: COB	16,991.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,863.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,117.00	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	118.00
CT SCAN	0.00	1,206.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,177.00	966.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	134.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,363.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	924.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,116.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	893.00	801.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,106.00	0.00			

TOTAL ANCILLARY	23,596.00	3,225.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,596.00	3,225.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	37,632.50	ADJUSTMENTS	0.00
COVERED CHARGES	35,297.50	CONTRACTUAL ALLOW	32,332.68
NON-COVERD CHARGES	2,335.00	TOTAL MEDICAID LIAB	2,964.82
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	2,883.82
		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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,723.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	155.00	104.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,327.00	853.00	OTHER THERAPEUTIC SVC	0.00	938.00
CT SCAN	5,381.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,480.00	243.00
EKG/ECG	70.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	402.00	197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	18,759.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	35,297.50	2,335.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,297.50	2,335.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	57,534.50	ADJUSTMENTS	0.00
COVERED CHARGES	56,723.50	CONTRACTUAL ALLOW	45,633.04
NON-COVERD CHARGES	811.00	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	11,087.46

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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,143.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,231.00	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	687.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	710.00	54.00
EKG/ECG	0.00	70.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,319.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,232.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	56,723.50	811.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,723.50	811.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,832,590.74	ADJUSTMENTS	4,655,508.07
COVERED CHARGES	16,107,893.76	CONTRACTUAL ALLOW	10,032,542.83
NON-COVERD CHARGES	724,696.98	TOTAL MEDICAID LIAB	6,075,350.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,075,350.93

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,621	0	3,997,838.00	56,190.00
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	2,621	0	3,997,838.00	56,190.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	59	0	181,838.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	181,838.00	0.00
TOTAL ACCOMODATIONS	2,680	0	4,179,676.00	56,190.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,524,117.00	96,135.00	OTHER LAB	94,561.00	0.00
MED/SURG SUPPLY	2,481,501.07	145,175.98	RECREATIONAL THERAPY	984.00	0.00
LABORATORY-GENERAL	433,440.00	45,087.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164,787.13	0.00	OTHER THERAPEUTIC SVC	16,558.00	12,214.00
CT SCAN	146,082.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	852,086.00	45,000.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,805.00	0.00	MRI SERVICES	56,730.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,334,750.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,060,116.00	207,625.00	FREE STANDING CLINIC	0.00	0.00
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	66,550.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,492,710.00	13,284.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	884,848.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	272,706.00	14,884.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,878.39	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,160.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,393.00	0.00			
AMBULATORY SURGERY	57,485.00	22,552.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,024.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,495.00	0.00			

TOTAL ANCILLARY	11,928,217.76	668,506.98
TOTAL ACCOMODATIONS	4,179,676.00	56,190.00
TOTAL CHARGES	16,107,893.76	724,696.98

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	825,225.14	ADJUSTMENTS	0.00
COVERED CHARGES	819,069.14	CONTRACTUAL ALLOW	661,591.64
NON-COVERD CHARGES	6,156.00	TOTAL MEDICAID LIAB	157,477.50
		LESS: COB	157,477.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	139	0	214,199.00	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	139	0	214,199.00	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	139	0	214,199.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,455.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57,914.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,892.00	0.00	EDUCATION & TRAINING	4,602.00	0.00
RADIOLOGY-DIAGNOSTIC	1,436.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,247.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,608.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	984.00	0.00	MRI SERVICES	3,447.00	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	158,306.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	5,580.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,550.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	52,185.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,609.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	40.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	536.00
OTHER IMAGING SERVICE	1,635.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	604,870.14	6,156.00
TOTAL ACCOMODATIONS	214,199.00	0.00
TOTAL CHARGES	819,069.14	6,156.00

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 04/01/17 THROUGH 03/31/18
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	9718249981008	09/01/17 - 01/18/18	09/17/18	0.00	536.00	0.00	157,477.50	0.00
TOTAL				0.00	536.00	0.00	157,477.50	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,536,868.29	ADJUSTMENTS	178,154.47
COVERED CHARGES	5,354,028.00	CONTRACTUAL ALLOW	3,598,190.97
NON-COVERD CHARGES	1,182,840.29	TOTAL MEDICAID LIAB	1,755,837.03
		LESS: COB	38,252.02
		LESS: COPAYMENT	4,542.00
		REIMBURSEMENT	1,713,043.01
		ALL OTHER	505,981.85
		FEE SCHEDULE-LAB	29,944.96
		INJECTABLE DRUGS	1,177,116.20

TOTAL NUMBER OF CLAIMS 1,410

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,829.00	23,185.00	OTHER LAB	20,039.00	3,011.00
MED/SURG SUPPLY	39,403.00	0.00	RECREATIONAL THERAPY	328.00	5,506.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	5,047.00
RADIOLOGY-DIAGNOSTIC	16,908.00	5,700.00	OTHER THERAPEUTIC SVC	339.00	5,509.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	190,597.00	222,971.09	FEE SCHEDULE LAB	257,300.00	1,904.00
EKG/ECG	328.00	0.00	MRI SERVICES	366,158.00	84,937.00
IV THERAPY	13,618.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	82.00	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	244.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,701,827.00	429,186.00
RADIOLOGY THERAPEUTIC	126,516.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	93,131.00	226,956.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,939.00	88,849.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	685.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	237,641.00	9,732.00	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	NO CC/INVALID REV CODE	0.00	26,116.00
OTHER IMAGING SERVICE	19,525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	12,333.00	696.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189,059.00	42,606.00			

TOTAL ANCILLARY	5,354,028.00	1,182,840.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,354,028.00	1,182,840.29

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 04/01/17 THROUGH 03/31/18
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	2217207004304	04/11/17 - 04/11/17	07/31/17	0.00	129.00	0.00	0.00	0.00
952	2217207004304	05/08/17 - 05/08/17	07/31/17	0.00	201.00	0.00	0.00	0.00
952	5917283000548	07/12/17 - 07/12/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/25/17 - 07/25/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/17/17 - 07/17/17	10/16/17	0.00	268.00	0.00	0.00	0.00
952	5917283000548	07/26/17 - 07/26/17	10/16/17	0.00	172.00	0.00	0.00	0.00
952	5917283000548	08/08/17 - 08/08/17	10/16/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	09/25/17 - 09/25/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310040825	09/14/17 - 09/14/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310040825	10/19/17 - 10/19/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	10/05/17 - 10/05/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	09/29/17 - 09/29/17	11/13/17	0.00	86.00	0.00	0.00	0.00
952	2017310040825	09/25/17 - 09/25/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310040825	09/22/17 - 09/22/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310040825	09/18/17 - 09/18/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017310040825	10/06/17 - 10/06/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017310041558	10/23/17 - 10/23/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/20/17 - 10/20/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/06/17 - 10/06/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/05/17 - 10/05/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/25/17 - 10/25/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/17/17 - 10/17/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/11/17 - 10/11/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017310041558	10/13/17 - 10/13/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017312071560	09/29/17 - 09/29/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	09/25/17 - 09/25/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/19/17 - 10/19/17	11/13/17	0.00	67.00	0.00	0.00	0.00
952	2017312071560	10/12/17 - 10/12/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	2017312071560	10/27/17 - 10/27/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/25/17 - 10/25/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/19/17 - 10/19/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017312071560	10/16/17 - 10/16/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/09/17 - 10/09/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/06/17 - 10/06/17	11/13/17	0.00	172.00	0.00	0.00	0.00
952	2017312071560	10/04/17 - 10/04/17	11/13/17	0.00	129.00	0.00	0.00	0.00
952	2017312071560	10/03/17 - 10/03/17	11/13/17	0.00	258.00	0.00	0.00	0.00
952	2017312071560	10/02/17 - 10/02/17	11/13/17	0.00	86.00	0.00	0.00	0.00
952	2017312071560	10/10/17 - 10/10/17	11/13/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/20/17 - 09/20/17	11/20/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/18/17 - 09/18/17	11/20/17	0.00	268.00	0.00	0.00	0.00
952	5917321011355	09/22/17 - 09/22/17	11/20/17	0.00	129.00	0.00	0.00	0.00
952	5917321011355	09/15/17 - 09/15/17	11/20/17	0.00	43.00	0.00	0.00	0.00

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	5917321011355	09/13/17 - 09/13/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/12/17 - 09/12/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/06/17 - 09/06/17	11/20/17	0.00	172.00	0.00	0.00	0.00
952	5917321011355	09/01/17 - 09/01/17	11/20/17	0.00	86.00	0.00	0.00	0.00
952	2017331032304	09/01/17 - 09/01/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	08/23/17 - 08/23/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	08/09/17 - 08/09/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/03/17 - 08/03/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/31/17 - 07/31/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	07/27/17 - 07/27/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/21/17 - 07/21/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/08/17 - 08/08/17	12/04/17	0.00	129.00	0.00	0.00	0.00
952	2017331032304	09/01/17 - 09/01/17	12/04/17	0.00	134.00	0.00	0.00	0.00
952	2017331032304	08/21/17 - 08/21/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	09/06/17 - 09/06/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/30/17 - 08/30/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	08/23/17 - 08/23/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	08/11/17 - 08/11/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	2017331032304	07/31/17 - 07/31/17	12/04/17	0.00	67.00	0.00	0.00	0.00
952	2017331032304	07/25/17 - 07/25/17	12/04/17	0.00	201.00	0.00	0.00	0.00
952	5917339002490	11/01/17 - 11/01/17	12/11/17	0.00	201.00	0.00	0.00	0.00
952	5917339002490	10/12/17 - 10/12/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	11/07/17 - 11/07/17	12/11/17	0.00	134.00	0.00	0.00	0.00
952	5917339002490	11/02/17 - 11/02/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	10/18/17 - 10/18/17	12/11/17	0.00	268.00	0.00	0.00	0.00
952	5917339002490	11/07/17 - 11/07/17	12/11/17	0.00	86.00	0.00	0.00	0.00
952	5917339002490	11/03/17 - 11/03/17	12/11/17	0.00	129.00	0.00	0.00	0.00
952	5917339002490	10/31/17 - 10/31/17	12/11/17	0.00	129.00	0.00	0.00	0.00
952	5917339002490	10/30/17 - 10/30/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917339002490	10/23/17 - 10/23/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917339002490	10/04/17 - 10/04/17	12/11/17	0.00	172.00	0.00	0.00	0.00
952	5917355006395	11/06/17 - 11/06/17	12/25/17	0.00	201.00	0.00	0.00	0.00
952	5917355006395	11/16/17 - 11/16/17	12/25/17	0.00	268.00	0.00	0.00	0.00
952	5917355006395	11/10/17 - 11/10/17	12/25/17	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/21/17 - 12/21/17	01/22/18	0.00	268.00	0.00	0.00	0.00
952	2018018076485	11/30/17 - 11/30/17	01/22/18	0.00	268.00	0.00	0.00	0.00
952	2018018076485	12/29/17 - 12/29/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/27/17 - 12/27/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/22/17 - 12/22/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/20/17 - 12/20/17	01/22/18	0.00	129.00	0.00	0.00	0.00
952	2018018076485	12/15/17 - 12/15/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/14/17 - 12/14/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/07/17 - 12/07/17	01/22/18	0.00	129.00	0.00	0.00	0.00
952	2018018076485	11/29/17 - 11/29/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	2018018076485	12/19/17 - 12/19/17	01/22/18	0.00	172.00	0.00	0.00	0.00
952	5918030001998	11/16/17 - 11/16/17	02/05/18	0.00	268.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

952	5918030001998	12/01/17 - 12/01/17	02/05/18	0.00	129.00	0.00	0.00	0.00
952	5918030001998	11/14/17 - 11/14/17	02/05/18	0.00	129.00	0.00	0.00	0.00
952	5918044001967	12/14/17 - 12/14/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	12/04/17 - 12/04/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	11/21/17 - 11/21/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918044001967	11/17/17 - 11/17/17	02/19/18	0.00	201.00	0.00	0.00	0.00
952	5918065001722	01/03/18 - 01/03/18	03/12/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	01/11/18 - 01/11/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	01/10/18 - 01/10/18	03/26/18	0.00	201.00	0.00	0.00	0.00
952	2018079077121	01/03/18 - 01/03/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	2018079077121	02/05/18 - 02/05/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	02/02/18 - 02/02/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/31/18 - 01/31/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/29/18 - 01/29/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/24/18 - 01/24/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018079077121	01/12/18 - 01/12/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/25/18 - 01/25/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	02/01/18 - 02/01/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	01/26/18 - 01/26/18	03/26/18	0.00	268.00	0.00	0.00	0.00
952	5918080000801	02/08/18 - 02/08/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/29/18 - 01/29/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/26/18 - 01/26/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	5918080000801	01/23/18 - 01/23/18	03/26/18	0.00	172.00	0.00	0.00	0.00
952	2018095005628	01/29/18 - 01/29/18	04/09/18	0.00	201.00	0.00	0.00	0.00
952	2018107075535	12/04/17 - 12/04/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/01/17 - 12/01/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/18/17 - 12/18/17	04/23/18	0.00	268.00	0.00	0.00	0.00
952	2018107075535	12/27/17 - 12/27/17	04/23/18	0.00	301.00	0.00	0.00	0.00
952	2018107075535	12/15/17 - 12/15/17	04/23/18	0.00	129.00	0.00	0.00	0.00
952	2018107075535	12/11/17 - 12/11/17	04/23/18	0.00	172.00	0.00	0.00	0.00
952	2018114080142	04/03/18 - 04/03/18	04/30/18	0.00	276.00	0.00	0.00	0.00
952	2018114080142	04/02/18 - 04/02/18	04/30/18	0.00	276.00	0.00	0.00	0.00
952	2018114080142	03/21/18 - 03/21/18	04/30/18	0.00	268.00	0.00	0.00	0.00
952	2018114080142	03/20/18 - 03/20/18	04/30/18	0.00	134.00	0.00	0.00	0.00
952	2018114080142	03/29/18 - 03/29/18	04/30/18	0.00	268.00	0.00	0.00	0.00
952	2018114080142	03/22/18 - 03/22/18	04/30/18	0.00	172.00	0.00	0.00	0.00
952	2018114080142	03/20/18 - 03/20/18	04/30/18	0.00	134.00	0.00	0.00	0.00
952	5918122000924	12/29/17 - 12/29/17	05/07/18	0.00	268.00	0.00	0.00	0.00
952	2218131009106	03/23/18 - 03/23/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/28/18 - 02/28/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/19/18 - 02/19/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/15/18 - 02/15/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	2218131009106	02/07/18 - 02/07/18	05/14/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/24/18 - 01/24/18	06/18/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/22/18 - 01/22/18	06/18/18	0.00	201.00	0.00	0.00	0.00
952	5918162001179	01/19/18 - 01/19/18	06/18/18	0.00	201.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

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952	5918162001179	01/02/18 - 01/02/18	06/18/18	0.00	201.00	0.00	0.00	0.00
TOTAL				0.00	26,116.00	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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	340,148.00	ADJUSTMENTS	0.00
COVERED CHARGES	243,435.00	CONTRACTUAL ALLOW	92,707.55
NON-COVERD CHARGES	96,713.00	TOTAL MEDICAID LIAB	150,727.45
		LESS: COB	150,430.45
		LESS: COPAYMENT	297.00
		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
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
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ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.00	920.00	OTHER LAB	1,839.00	1,291.00
MED/SURG SUPPLY	2,667.00	0.00	RECREATIONAL THERAPY	0.00	820.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	777.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	214.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,848.00	34,978.00	FEE SCHEDULE LAB	2,096.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,416.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	168,031.00	52.00
RADIOLOGY THERAPEUTIC	658.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,471.00	30,786.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,653.00	10,253.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	30.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,590.00	682.00	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	NO CC/INVALID REV CODE	0.00	4,874.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,084.00	11,004.00			

TOTAL ANCILLARY	243,435.00	96,713.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	243,435.00	96,713.00

SHEPHERD CENTER
2020 PEACHTREE RD NW
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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
952	2018093002086	12/08/17 - 12/08/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	12/01/17 - 12/01/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/15/17 - 11/15/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/10/17 - 11/10/17	04/09/18	0.00	86.00	0.00	15,570.80	0.00
952	2018093002086	11/06/17 - 11/06/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/01/17 - 11/01/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	10/26/17 - 10/26/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/29/17 - 11/29/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/08/17 - 11/08/17	04/09/18	0.00	172.00	0.00	15,570.80	0.00
952	2018093002086	11/01/17 - 11/01/17	04/09/18	0.00	268.00	0.00	15,570.80	0.00
952	2018178028748	03/30/18 - 03/30/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/20/18 - 03/20/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/26/18 - 03/26/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	2018178028748	03/23/18 - 03/23/18	07/02/18	0.00	201.00	0.00	1,056.00	0.00
952	5918256000846	11/07/17 - 11/07/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/22/17 - 12/22/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/18/17 - 12/18/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/15/17 - 12/15/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/14/17 - 12/14/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/07/17 - 12/07/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	12/04/17 - 12/04/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/28/17 - 11/28/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/21/17 - 11/21/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/17/17 - 11/17/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/13/17 - 11/13/17	09/17/18	0.00	201.00	0.00	15,970.00	0.00
952	5918256000846	11/28/17 - 11/28/17	09/17/18	0.00	129.00	0.00	15,970.00	0.00
TOTAL				0.00	4,874.00	0.00	351,572.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	434,922.00	ADJUSTMENTS	111,404.10
COVERED CHARGES	431,661.00	CONTRACTUAL ALLOW	286,800.57
NON-COVERD CHARGES	3,261.00	TOTAL MEDICAID LIAB	144,860.43
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	144,824.43

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	669.00	2,634.00	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	6,385.00	575.00
EKG/ECG	0.00	0.00	MRI SERVICES	13,164.00	0.00
IV THERAPY	18,271.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	393,056.00	52.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116.00	0.00			

TOTAL ANCILLARY	431,661.00	3,261.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	431,661.00	3,261.00

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 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

WELLSTAR 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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	34,953,624.38	ADJUSTMENTS	749,617.30
COVERED CHARGES	34,467,566.91	CONTRACTUAL ALLOW	30,558,985.95
NON-COVERD CHARGES	486,057.47	TOTAL MEDICAID LIAB	3,908,580.96
		LESS: COB	65,289.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,843,291.58

TOTAL NUMBER OF ADMISSIONS 567

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,011	0	1,429,881.00	99,811.50
ROUTINE NURSERY	731	0	1,145,971.50	24,975.40
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,742	0	2,575,852.50	124,786.90
SPECIAL CARE SERVICES				
CCU	139	0	349,446.00	0.00
ICU	931	0	4,022,068.00	11,376.80
NICU	63	0	243,124.80	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,133	0	4,614,638.80	11,376.80
TOTAL ACCOMODATIONS	2,875	0	7,190,491.30	136,163.70

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,204,186.60	22,473.30	OTHER LAB	116,047.00	1,866.10
MED/SURG SUPPLY	2,990,803.55	47,025.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,455,334.78	17,933.57	EDUCATION & TRAINING	8,973.70	0.00
RADIOLOGY-DIAGNOSTIC	409,172.30	572.40	OTHER THERAPEUTIC SVC	0.00	1,026.00
CT SCAN	1,084,928.20	107,009.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	237,076.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	139,428.80	0.00	MRI SERVICES	237,397.20	0.00
IV THERAPY	56,246.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,844,143.15	15,631.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,885,902.30	0.00	REHAB THERAPY	134.50	0.00
RESPIRATORY SERVICES	2,799,330.00	5,797.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	422,408.46	0.00	AMBULANCE	0.00	1,038.10
GI SERVICES	160,546.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	572,846.80	2,962.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	442,635.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	160,383.70	0.00	INJECTABLE DRUGS	72,860.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	94,883.35	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	182,584.99	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	167,119.40	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,750.00	418.00	TRAUMA RESPONSE	0.00	20,870.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	476,453.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	184,227.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,609.40	100,669.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	103,434.90	0.00			
AUDIOLOGY	102,263.00	0.00			
CARDIOLOGY	461,419.10	4,600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,842.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,702.40	0.00			

TOTAL ANCILLARY	27,277,075.61	349,893.77
TOTAL ACCOMODATIONS	7,190,491.30	136,163.70
TOTAL CHARGES	34,467,566.91	486,057.47

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,261.83	ADJUSTMENTS	0.00
COVERED CHARGES	138,570.03	CONTRACTUAL ALLOW	96,027.09
NON-COVERD CHARGES	691.80	TOTAL MEDICAID LIAB	42,542.94
		LESS: COB	42,542.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12	0	16,734.00	691.80
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	16,734.00	691.80
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	2	0	11,376.80	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	11,376.80	0.00
TOTAL ACCOMODATIONS	14	0	28,110.80	691.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,933.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,163.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,026.20	0.00	EDUCATION & TRAINING	349.00	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	772.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,532.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,217.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,813.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,103.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,797.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,333.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	668.00	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	1,359.73	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	333.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,056.00	0.00			

TOTAL ANCILLARY	110,459.23	0.00
TOTAL ACCOMODATIONS	28,110.80	691.80
TOTAL CHARGES	138,570.03	691.80

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,482,919.54	ADJUSTMENTS	116,219.79
COVERED CHARGES	6,011,709.90	CONTRACTUAL ALLOW	5,407,372.33
NON-COVERD CHARGES	471,209.64	TOTAL MEDICAID LIAB	604,337.57
		LESS: COB	7,047.98
		LESS: COPAYMENT	1,680.00
		REIMBURSEMENT	595,609.59
		ALL OTHER	538,008.51
		FEE SCHEDULE-LAB	37,638.72
		INJECTABLE DRUGS	19,962.36

TOTAL NUMBER OF CLAIMS 1,512

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210,674.06	0.00	OTHER LAB	40,138.30	0.00
MED/SURG SUPPLY	357,792.60	294.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228,200.00	2,010.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	790,494.40	74,872.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,963.26	FEE SCHEDULE LAB	973,616.40	47,373.50
EKG/ECG	94,389.10	4,636.20	MRI SERVICES	134,234.30	8,180.00
IV THERAPY	344,428.80	38,408.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	306,026.43	70,151.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,096.00	117.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,061.00	0.00	AMBULANCE	0.00	4,171.20
GI SERVICES	22,211.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,246,533.10	3,210.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,070.80	1,100.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	517,716.24	87,618.75
RADIOLOGY THERAPEUTIC	18,846.20	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	2,609.74	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,961.80	2,362.90	TRAUMA RESPONSE	0.00	7,019.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,698.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	100,744.10	24,148.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,806.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,637.00	6,684.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,456.90	18,388.50			
AMBULATORY SURGERY	169,704.85	60,971.52			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,126.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,851.24	1,112.00			

TOTAL ANCILLARY	6,011,709.90	471,209.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,011,709.90	471,209.64

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	139,513.44	ADJUSTMENTS	0.00
COVERED CHARGES	75,013.44	CONTRACTUAL ALLOW	17,109.28
NON-COVERD CHARGES	64,500.00	TOTAL MEDICAID LIAB	57,904.16
		LESS: COB	57,883.16
		LESS: COPAYMENT	21.00
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,525.80	600.00	OTHER LAB	3,248.00	0.00
MED/SURG SUPPLY	1,490.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,883.00	669.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,313.00	32,637.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,442.60	763.00
EKG/ECG	2,048.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,524.00	222.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	21,074.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,620.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,910.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,879.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,558.60	390.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	142.67	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,257.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,851.00	900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,577.10	0.00			

TOTAL ANCILLARY	75,013.44	64,500.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	75,013.44	64,500.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	284,982.20	ADJUSTMENTS	105.88
COVERED CHARGES	259,831.10	CONTRACTUAL ALLOW	253,621.76
NON-COVERD CHARGES	25,151.10	TOTAL MEDICAID LIAB	6,209.34
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	5,987.34
		TOTAL NUMBER OF CLAIMS	111

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,124.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,616.10	302.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,317.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,130.20	21,295.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,240.80	1,934.10
EKG/ECG	3,602.80	0.00	MRI SERVICES	5,824.60	0.00
IV THERAPY	12,443.80	568.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	139,093.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,437.35	1,051.20
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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	259,831.10	25,151.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	259,831.10	25,151.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,611.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,591.40	CONTRACTUAL ALLOW	1,059.00
NON-COVERD CHARGES	19.80	TOTAL MEDICAID LIAB	1,532.40
		LESS: COB	1,529.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	816.20	19.80
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	1,775.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	2,591.40	19.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,591.40	19.80

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,205,362.53	ADJUSTMENTS	10,872.20
COVERED CHARGES	1,072,547.03	CONTRACTUAL ALLOW	1,012,700.43
NON-COVERD CHARGES	132,815.50	TOTAL MEDICAID LIAB	59,846.60
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	59,783.60

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,194.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82,190.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,423.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,647.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,797.25	FEE SCHEDULE LAB	15,401.10	0.00
EKG/ECG	772.70	0.00	MRI SERVICES	6,578.60	0.00
IV THERAPY	36,109.10	13,068.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,214.90	107,514.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,158.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,416.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,122.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,555.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132,436.19	10,167.95
RADIOLOGY THERAPEUTIC	1,624.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	598,587.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,426.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,686.80	267.00			

TOTAL ANCILLARY	1,072,547.03	132,815.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,072,547.03	132,815.50

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	6,358,775.56	ADJUSTMENTS	37,649.35
COVERED CHARGES	6,070,246.81	CONTRACTUAL ALLOW	4,827,370.60
NON-COVERD CHARGES	288,528.75	TOTAL MEDICAID LIAB	1,242,876.21
		LESS: COB	3,955.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,238,920.34

TOTAL NUMBER OF ADMISSIONS 145

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	471	0	491,079.00	175,053.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	471	0	491,079.00	175,053.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	71	0	200,301.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	71	0	200,301.00	0.00
TOTAL ACCOMODATIONS	542	0	691,380.00	175,053.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449,029.50	0.00	OTHER LAB	49,680.00	0.00
MED/SURG SUPPLY	211,592.00	500.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,174,968.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166,083.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	351,123.75	106,222.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,365.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	56,166.00	0.00	MRI SERVICES	129,083.50	0.00
IV THERAPY	20,813.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	593,085.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	204,242.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	226,748.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,265.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	261,459.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,324.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,844.00
LABORATORY PATHOLOGIC	8,333.50	0.00	INJECTABLE DRUGS	664,004.09	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,082.73	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,135.31	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	15,413.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	408.00	349.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	224,949.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,201.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,452.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,351.75	559.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	237,067.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,983.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,453.50	0.00			

TOTAL ANCILLARY	5,378,866.81	113,475.75
TOTAL ACCOMODATIONS	691,380.00	175,053.00
TOTAL CHARGES	6,070,246.81	288,528.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,191,644.13	ADJUSTMENTS	26,003.60
COVERED CHARGES	9,100,588.70	CONTRACTUAL ALLOW	8,317,223.46
NON-COVERD CHARGES	1,091,055.43	TOTAL MEDICAID LIAB	783,365.24
		LESS: COB	2,853.23
		LESS: COPAYMENT	1,251.00
		REIMBURSEMENT	779,261.01
		ALL OTHER	692,608.09
		FEE SCHEDULE-LAB	76,122.56
		INJECTABLE DRUGS	10,530.36

TOTAL NUMBER OF CLAIMS 2,470

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,063.04	134,147.63	OTHER LAB	98,037.25	0.00
MED/SURG SUPPLY	103,687.00	885.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,044,297.75	19,608.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,479,088.00	379,248.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,465.25	20,304.29	FEE SCHEDULE LAB	1,963,406.25	121,546.50
EKG/ECG	161,511.75	0.00	MRI SERVICES	43,287.50	30,620.50
IV THERAPY	379,032.25	10,878.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	334,742.01	106,599.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,312.25	8,249.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	141,018.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,951.91	32,823.59	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,376,127.62	17,861.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	93,262.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	121,182.37	87,274.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,795.75	21,641.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,515.00	6,585.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,634.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,003.25	4,029.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,608.50	286.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	94,459.75	46,531.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,527.00	2,148.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,613.75	31,061.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	206,630.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	164,962.25	6,089.50			

TOTAL ANCILLARY	9,100,588.70	1,091,055.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,100,588.70	1,091,055.43

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	153,622.42	ADJUSTMENTS	0.00
COVERED CHARGES	94,357.67	CONTRACTUAL ALLOW	51,583.89
NON-COVERD CHARGES	59,264.75	TOTAL MEDICAID LIAB	42,773.78
		LESS: COB	42,737.78
		LESS: COPAYMENT	36.00
		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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	773.62	1,544.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,829.25	1,835.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,152.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,226.50	7,067.25
EKG/ECG	2,294.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,338.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,036.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	535.25	27,990.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,511.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,017.25	5,593.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,319.05	1,236.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	451.50	227.50	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,266.00	1,510.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	911.25	559.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,553.00	0.00			

TOTAL ANCILLARY	94,357.67	59,264.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,357.67	59,264.75

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,053,909.99	ADJUSTMENTS	0.00
COVERED CHARGES	952,805.28	CONTRACTUAL ALLOW	930,597.10
NON-COVERD CHARGES	101,104.71	TOTAL MEDICAID LIAB	22,208.18
		LESS: COB	0.00
		LESS: COPAYMENT	768.00
		REIMBURSEMENT	21,440.18
		TOTAL NUMBER OF CLAIMS	397

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,372.78	10,026.67	OTHER LAB	6,795.00	0.00
MED/SURG SUPPLY	635.25	61.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,731.25	9,334.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	91,290.25	49,348.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229,802.00	4,580.50
EKG/ECG	11,764.50	0.00	MRI SERVICES	0.00	6,722.75
IV THERAPY	37,871.50	1,048.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,660.25	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	403,167.00	711.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,060.00	10,956.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	70.75	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,655.50	8,244.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	952,805.28	101,104.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	952,805.28	101,104.71

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	16,816.37	ADJUSTMENTS	0.00
COVERED CHARGES	16,000.75	CONTRACTUAL ALLOW	11,189.78
NON-COVERD CHARGES	815.62	TOTAL MEDICAID LIAB	4,810.97
		LESS: COB	4,798.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	365.62	OTHER LAB	1,852.25	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	3,706.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,852.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	295.75	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,207.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86.00	450.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	16,000.75	815.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,000.75	815.62

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	198,808.85	ADJUSTMENTS	0.00
COVERED CHARGES	185,108.70	CONTRACTUAL ALLOW	168,794.65
NON-COVERD CHARGES	13,700.15	TOTAL MEDICAID LIAB	16,314.05
		LESS: COB	4,746.94
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	11,552.11
		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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,640.25	2,150.46	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37,010.00	78.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,900.00	539.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,932.82	FEE SCHEDULE LAB	7,280.50	0.00
EKG/ECG	465.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,171.20	4,842.80	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	30,729.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,238.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,805.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,473.50	954.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,201.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	4,354.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,040.00	0.00			

TOTAL ANCILLARY	185,108.70	13,700.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,108.70	13,700.15

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,237,557.62	ADJUSTMENTS	8,846.48
COVERED CHARGES	1,237,253.62	CONTRACTUAL ALLOW	954,017.02
NON-COVERD CHARGES	304.00	TOTAL MEDICAID LIAB	283,236.60
		LESS: COB	467.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	282,769.37

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	129	0	125,388.00	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	129	0	125,388.00	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4	0	7,260.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	7,260.00	0.00
TOTAL ACCOMODATIONS	133	0	132,648.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,996.98	0.00	OTHER LAB	2,346.20	0.00
MED/SURG SUPPLY	105,217.00	304.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	91,938.52	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,617.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,588.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,567.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,672.00	0.00	MRI SERVICES	6,952.00	0.00
IV THERAPY	4,131.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	232,051.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,844.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,199.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,232.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,774.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	522.00	0.00	INJECTABLE DRUGS	120,802.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,979.49	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	302,495.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,310.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,734.65	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,068.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,104,605.62	304.00
TOTAL ACCOMODATIONS	132,648.00	0.00
TOTAL CHARGES	1,237,253.62	304.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,199,688.41	ADJUSTMENTS	31,797.24
COVERED CHARGES	1,076,761.45	CONTRACTUAL ALLOW	887,001.03
NON-COVERD CHARGES	122,926.96	TOTAL MEDICAID LIAB	189,760.42
		LESS: COB	0.00
		LESS: COPAYMENT	753.00
		REIMBURSEMENT	189,007.42
		ALL OTHER	183,883.83
		FEE SCHEDULE-LAB	4,690.85
		INJECTABLE DRUGS	432.74

TOTAL NUMBER OF CLAIMS 390

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,624.12	407.50	OTHER LAB	668.75	0.00
MED/SURG SUPPLY	46,001.50	1,105.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,582.00	857.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,938.40	10,638.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,444.49	2,801.18	FEE SCHEDULE LAB	62,502.39	2,506.14
EKG/ECG	5,712.00	0.00	MRI SERVICES	21,711.00	0.00
IV THERAPY	30,655.00	2,436.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	200,616.07	48,491.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	388.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,861.22	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,500.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,188.58	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,524.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,071.25	7,742.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,173.71	1,365.71	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	198.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,872.50	0.00
LITHOTRIPSY	0.00	41,505.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,611.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,036.10	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,504.17	649.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	254,724.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	850.50	0.00			

TOTAL ANCILLARY	1,076,761.45	122,926.96
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,076,761.45	122,926.96

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	74,363.91	ADJUSTMENTS	0.00
COVERED CHARGES	52,059.46	CONTRACTUAL ALLOW	27,189.77
NON-COVERD CHARGES	22,304.45	TOTAL MEDICAID LIAB	24,869.69
		LESS: COB	24,842.69
		LESS: COPAYMENT	27.00
		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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,990.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,741.25	312.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	408.00	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	670.00	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,580.39	18,883.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,379.38	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	6,052.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	366.00	1,954.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	1,134.00
LITHOTRIPSY	8,301.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,570.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	52,059.46	22,304.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,059.46	22,304.45

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,557.03	ADJUSTMENTS	0.00
COVERED CHARGES	1,557.03	CONTRACTUAL ALLOW	1,333.27
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	223.76
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	220.76

TOTAL NUMBER OF CLAIMS 4

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 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	33.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133.93	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	1,377.60	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	12.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,557.03	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,557.03	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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
1355 INDEPENDENCE DR
AUGUSTA,GA 30901-1037

PROVIDER NUMBER
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	25,045.08	ADJUSTMENTS	0.00
COVERED CHARGES	25,045.08	CONTRACTUAL ALLOW	11,177.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	13,867.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,867.96

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	6	0	3,456.00	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	3,456.00	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	3,456.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,374.21	0.00	OTHER LAB	946.00	0.00
MED/SURG SUPPLY	1,346.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,118.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128.00	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	2,257.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,184.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335.08	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	559.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	21,589.08	0.00
TOTAL ACCOMODATIONS	3,456.00	0.00
TOTAL CHARGES	25,045.08	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	498,869.26	ADJUSTMENTS	6,086.95
COVERED CHARGES	458,561.79	CONTRACTUAL ALLOW	277,511.60
NON-COVERD CHARGES	40,307.47	TOTAL MEDICAID LIAB	181,050.19
		LESS: COB	0.00
		LESS: COPAYMENT	643.65
		REIMBURSEMENT	180,406.54
		ALL OTHER	163,406.93
		FEE SCHEDULE-LAB	15,841.40
		INJECTABLE DRUGS	1,158.21

TOTAL NUMBER OF CLAIMS 500

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,413.43	11,661.87	OTHER LAB	15,316.98	0.00
MED/SURG SUPPLY	7,041.69	243.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,346.00	1,895.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,542.00	3,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,468.00	1,298.00	FEE SCHEDULE LAB	96,117.00	3,501.25
EKG/ECG	7,424.00	384.00	MRI SERVICES	2,250.00	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	8,689.22	2,755.06	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,455.10	5,698.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,764.70	5,237.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,106.00	30.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	129.00	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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,885.67	3,575.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	672.00	0.00			

TOTAL ANCILLARY	458,561.79	40,307.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	458,561.79	40,307.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	42,015.73	ADJUSTMENTS	0.00
COVERED CHARGES	40,445.41	CONTRACTUAL ALLOW	37,895.41
NON-COVERD CHARGES	1,570.32	TOTAL MEDICAID LIAB	2,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,457.00
		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

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518.75	199.87	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	372.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,620.00	150.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,996.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,626.50	311.00
EKG/ECG	512.00	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	891.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,961.03	442.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	947.68	467.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	40,445.41	1,570.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,445.41	1,570.32

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL
1740 LIONS CLUB ROAD
MADISON,GA 30650-4762

PROVIDER NUMBER
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	32,834,949.04	ADJUSTMENTS	610,529.54
COVERED CHARGES	32,176,859.63	CONTRACTUAL ALLOW	24,920,774.85
NON-COVERD CHARGES	658,089.41	TOTAL MEDICAID LIAB	7,256,084.78
		LESS: COB	42,140.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,213,944.00

TOTAL NUMBER OF ADMISSIONS 805

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,585	0	3,240,325.00	301,927.00
ROUTINE NURSERY	436	0	731,659.00	17,451.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,021	0	3,971,984.00	319,378.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	618	0	2,132,438.00	0.00
NICU	29	0	114,811.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	647	0	2,247,249.00	0.00
TOTAL ACCOMODATIONS	3,668	0	6,219,233.00	319,378.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,105,435.85	33,897.64	OTHER LAB	237,500.00	1,833.00
MED/SURG SUPPLY	691,770.90	2,105.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,738,453.00	19,927.00	EDUCATION & TRAINING	17,017.00	0.00
RADIOLOGY-DIAGNOSTIC	617,980.00	504.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,648,683.00	6,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	262,768.39	16,678.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	346,875.00	0.00	MRI SERVICES	410,550.00	0.00
IV THERAPY	3,151.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,070,991.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	456,713.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,192,101.00	20,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	255,125.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	351,573.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,529,875.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	374,141.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	201,980.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	56,064.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	141,206.20	7,194.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	95,357.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,177,948.00	155,468.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,002.00	1,854.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	207,786.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	335,714.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	385,836.00	31,168.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	154,089.00	41,860.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	703,322.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,669.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,948.80	0.00			

TOTAL ANCILLARY	25,957,626.63	338,711.41
TOTAL ACCOMODATIONS	6,219,233.00	319,378.00
TOTAL CHARGES	32,176,859.63	658,089.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	550,538.58	ADJUSTMENTS	0.00
COVERED CHARGES	543,138.58	CONTRACTUAL ALLOW	286,206.14
NON-COVERD CHARGES	7,400.00	TOTAL MEDICAID LIAB	256,932.44
		LESS: COB	256,932.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	66	0	83,886.00	6,534.00
ROUTINE NURSERY	15	0	40,784.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	81	0	124,670.00	6,534.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	9	0	35,631.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
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	35,631.00	0.00
TOTAL ACCOMODATIONS	90	0	160,301.00	6,534.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,495.00	0.00	OTHER LAB	4,779.00	0.00
MED/SURG SUPPLY	16,997.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,976.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,898.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,251.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,197.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,885.00	0.00	MRI SERVICES	3,189.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,896.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,874.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,315.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,455.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,165.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,501.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,649.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,841.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	209.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,526.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,659.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,390.00	866.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,858.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,785.00	0.00			

TOTAL ANCILLARY	382,837.58	866.00
TOTAL ACCOMODATIONS	160,301.00	6,534.00
TOTAL CHARGES	543,138.58	7,400.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	19,734,137.46	ADJUSTMENTS	340,168.49
COVERED CHARGES	16,321,717.81	CONTRACTUAL ALLOW	14,516,223.49
NON-COVERD CHARGES	3,412,419.65	TOTAL MEDICAID LIAB	1,805,494.32
		LESS: COB	112,990.34
		LESS: COPAYMENT	4,166.45
		REIMBURSEMENT	1,688,337.53
		ALL OTHER	1,515,119.99
		FEE SCHEDULE-LAB	120,230.27
		INJECTABLE DRUGS	52,987.27

TOTAL NUMBER OF CLAIMS 3,810

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	256,507.14	0.00	OTHER LAB	195,022.00	3,322.00
MED/SURG SUPPLY	444,464.64	58,885.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,547.00
RADIOLOGY-DIAGNOSTIC	697,555.00	113,646.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,453,629.00	575,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,344.00	11,108.02	FEE SCHEDULE LAB	2,122,178.00	186,703.00
EKG/ECG	390,720.00	15,540.00	MRI SERVICES	206,598.00	30,960.00
IV THERAPY	123,284.00	1,340.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	709,699.00	386,067.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,364.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,943.00	140,558.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	144,221.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	433,730.00	216,932.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,176,753.00	286,044.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	260,630.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	520,451.53	213,608.70
RADIOLOGY THERAPEUTIC	339,755.00	511,509.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,599.00	6,829.17	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,566.00	4,500.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	43,617.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	91,119.00	8,516.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,065.51	60,149.04
LITHOTRIPSY	0.00	32,504.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	438,378.00	207,279.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,792.00	23,376.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	122,956.00	92,425.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	514,067.00	136,296.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	114,943.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	384,383.99	43,313.00			

TOTAL ANCILLARY	16,321,717.81	3,412,419.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,321,717.81	3,412,419.65

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	543,516.46	ADJUSTMENTS	0.00
COVERED CHARGES	357,015.46	CONTRACTUAL ALLOW	210,380.30
NON-COVERD CHARGES	186,501.00	TOTAL MEDICAID LIAB	146,635.16
		LESS: COB	146,563.16
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,240.80	0.00	OTHER LAB	2,427.00	0.00
MED/SURG SUPPLY	19,409.30	1,860.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,707.00	3,555.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,720.00	47,690.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,185.00	10,070.00
EKG/ECG	8,325.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,082.00	65,186.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,410.00	1,452.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,521.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,315.00	13,153.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	129,334.00	5,142.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,364.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,028.90	3,616.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,009.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,108.66	1,456.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,250.00	19,433.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,557.00	2,204.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,799.00	11,683.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,222.80	0.00			

TOTAL ANCILLARY	357,015.46	186,501.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	357,015.46	186,501.00

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	554,850.70	ADJUSTMENTS	435.52
COVERED CHARGES	493,590.29	CONTRACTUAL ALLOW	480,164.69
NON-COVERD CHARGES	61,260.41	TOTAL MEDICAID LIAB	13,425.60
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	13,194.60
		TOTAL NUMBER OF CLAIMS	240

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,501.88	0.00	OTHER LAB	5,245.00	0.00
MED/SURG SUPPLY	4,278.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,515.00	3,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,778.00	19,493.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,042.00	2,954.00
EKG/ECG	6,105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,118.00	528.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	14,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,033.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,558.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	286,036.00	7,215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,799.35	3,850.41
RADIOLOGY THERAPEUTIC	1,551.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,671.00	9,004.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,793.95	0.00			

TOTAL ANCILLARY	493,590.29	61,260.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	493,590.29	61,260.41

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	27,283.43	ADJUSTMENTS	0.00
COVERED CHARGES	26,804.43	CONTRACTUAL ALLOW	19,527.72
NON-COVERD CHARGES	479.00	TOTAL MEDICAID LIAB	7,276.71
		LESS: COB	7,261.71
		LESS: COPAYMENT	15.00
		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 FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	409.52	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	1,514.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,360.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,327.00	80.00
EKG/ECG	555.00	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	13,273.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	365.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	26,804.43	479.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,804.43	479.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,060,313.10	ADJUSTMENTS	5,329.98
COVERED CHARGES	883,036.25	CONTRACTUAL ALLOW	802,996.55
NON-COVERD CHARGES	177,276.85	TOTAL MEDICAID LIAB	80,039.70
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	79,901.70
		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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,306.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,374.41	109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504.00	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	5,464.00	3,157.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,695.00	1,495.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,272.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	814.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,257.00	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	3,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	605,666.88	154,393.85
RADIOLOGY THERAPEUTIC	41,157.00	6,210.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	123,349.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,376.00	3,896.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,290.00	446.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,350.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,169.65	1,938.00			

TOTAL ANCILLARY	883,036.25	177,276.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	883,036.25	177,276.85

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

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 07/01/17 THROUGH 06/30/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	3,135,014.26	ADJUSTMENTS	0.00
COVERED CHARGES	3,047,234.06	CONTRACTUAL ALLOW	2,696,965.32
NON-COVERD CHARGES	87,780.20	TOTAL MEDICAID LIAB	350,268.74
		LESS: COB	1,823.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	348,445.16

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	83	0	228,511.00	87,780.20
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	83	0	228,511.00	87,780.20
SPECIAL CARE SERVICES				
CCU	307	0	1,266,028.56	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	307	0	1,266,028.56	0.00
TOTAL ACCOMODATIONS	390	0	1,494,539.56	87,780.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	332,915.30	0.00	OTHER LAB	1,697.85	0.00
MED/SURG SUPPLY	37,269.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	311,876.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,673.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,421.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,001.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	302.00	0.00	MRI SERVICES	5,946.00	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	579,523.10	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	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	67,449.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	64,453.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,520.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,373.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,246.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,158.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,869.10	0.00			

TOTAL ANCILLARY	1,552,694.50	0.00
TOTAL ACCOMODATIONS	1,494,539.56	87,780.20
TOTAL CHARGES	3,047,234.06	87,780.20

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE I
INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	10,120,136.13	ADJUSTMENTS	156,734.65
COVERED CHARGES	9,568,859.03	CONTRACTUAL ALLOW	6,320,442.23
NON-COVERD CHARGES	551,277.10	TOTAL MEDICAID LIAB	3,248,416.80
		LESS: COB	122,525.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,125,890.84

TOTAL NUMBER OF ADMISSIONS 317

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,120	0	1,654,741.00	103,659.00
ROUTINE NURSERY	153	0	229,440.00	62,400.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,273	0	1,884,181.00	166,059.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	142	0	872,306.00	0.00
NICU	88	0	213,840.00	211,200.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	230	0	1,086,146.00	211,200.00
TOTAL ACCOMODATIONS	1,503	0	2,970,327.00	377,259.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312,827.16	9,100.69	OTHER LAB	59,950.00	0.00
MED/SURG SUPPLY	236,152.16	3,322.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,361,199.00	19,110.00	EDUCATION & TRAINING	118.00	0.00
RADIOLOGY-DIAGNOSTIC	124,791.92	3,382.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	556,444.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	145,848.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	41,503.00	0.00	MRI SERVICES	179,752.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	721,594.00	2,174.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	101,235.00	590.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	215,059.00	23,478.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,708.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,534.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	399,122.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,934.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,548.60
LABORATORY PATHOLOGIC	50,427.00	0.00	INJECTABLE DRUGS	788,330.23	2,914.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	75,693.90	4,281.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,462.57	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	83,996.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,552.00	74.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	161,675.00	164.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	80,622.00
OTHER IMAGING SERVICE	42,544.00	2,872.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	96,209.00	10,299.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,513.00	10,086.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	344,993.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,658.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,707.00	0.00			

TOTAL ANCILLARY	6,598,532.03	174,018.10
TOTAL ACCOMODATIONS	2,970,327.00	377,259.00
TOTAL CHARGES	9,568,859.03	551,277.10

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2018005069148	12/11/17 - 12/18/17	01/15/18	0.00	8,958.00	0.00	0.00	0.00
615	2318050000048	11/09/17 - 11/15/17	02/26/18	0.00	8,958.00	0.00	2,182.54	0.00
615	2018192076564	02/03/18 - 02/05/18	07/16/18	0.00	8,958.00	0.00	0.00	0.00
614	5218256000144	05/16/18 - 06/06/18	09/17/18	0.00	4,479.00	0.00	7,051.88	0.00
615	2318263000309	12/30/17 - 01/01/18	10/01/18	0.00	8,958.00	0.00	1,654.83	0.00
614	2318264000125	06/26/18 - 06/30/18	10/01/18	0.00	4,479.00	0.00	1,685.58	0.00
615	2318270000275	06/29/18 - 07/02/18	10/08/18	0.00	8,958.00	0.00	990.91	0.00
615	2318281000118	02/13/18 - 02/14/18	10/22/18	0.00	8,958.00	0.00	1,242.78	0.00
615	2219042008578	05/31/18 - 06/05/18	02/18/19	0.00	8,958.00	0.00	0.00	0.00
615	2319225000397	04/17/18 - 04/22/18	08/26/19	0.00	8,958.00	0.00	1,613.87	0.00
TOTAL				0.00	80,622.00	0.00	16,422.39	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,901.25	ADJUSTMENTS	0.00
COVERED CHARGES	24,200.25	CONTRACTUAL ALLOW	4,504.29
NON-COVERD CHARGES	701.00	TOTAL MEDICAID LIAB	19,695.96
		LESS: COB	19,695.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3	0	4,383.00	327.00
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	4,383.00	327.00
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	4,383.00	327.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.58	0.00	OTHER LAB	936.00	0.00
MED/SURG SUPPLY	393.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,394.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,544.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,588.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	412.00	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	1,918.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,530.00	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	921.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	22.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	121.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,514.00	374.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	19,817.25	374.00
TOTAL ACCOMODATIONS	4,383.00	327.00
TOTAL CHARGES	24,200.25	701.00

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	2,736,246.25	ADJUSTMENTS	53,705.13
COVERED CHARGES	2,125,008.17	CONTRACTUAL ALLOW	1,742,092.83
NON-COVERD CHARGES	611,238.08	TOTAL MEDICAID LIAB	382,915.34
		LESS: COB	158.84
		LESS: COPAYMENT	1,044.00
		REIMBURSEMENT	381,712.50
		ALL OTHER	343,498.90
		FEE SCHEDULE-LAB	28,628.28
		INJECTABLE DRUGS	9,585.32

TOTAL NUMBER OF CLAIMS 817

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,428.27	16,944.32	OTHER LAB	14,976.00	936.00
MED/SURG SUPPLY	79,375.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,184.40	27,646.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	261,206.00	201,929.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,987.00	4,350.02	FEE SCHEDULE LAB	306,720.00	12,292.00
EKG/ECG	17,094.00	0.00	MRI SERVICES	172,430.00	48,405.00
IV THERAPY	2,370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	225,183.00	67,690.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,481.00	926.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,002.00	29,828.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	386,422.00	9,590.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,192.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	130,861.50	17,182.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	488.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	690.00	923.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,945.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	717.00	229.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,974.00	12,350.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,958.00
OTHER IMAGING SERVICE	87,316.00	26,276.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,467.00	54,277.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	97,883.00	59,834.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,558.00	239.00			

TOTAL ANCILLARY	2,125,008.17	611,238.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,125,008.17	611,238.08

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
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	2018117070735	04/19/18 - 04/19/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
615	2018117070735	04/19/18 - 04/19/18	05/07/18	0.00	4,479.00	0.00	0.00	0.00
TOTAL				0.00	8,958.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	103,666.82	ADJUSTMENTS	0.00
COVERED CHARGES	50,428.68	CONTRACTUAL ALLOW	25,708.27
NON-COVERD CHARGES	53,238.14	TOTAL MEDICAID LIAB	24,720.41
		LESS: COB	24,691.17
		LESS: COPAYMENT	29.24
		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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,329.24	1,872.49	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,070.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,699.00	364.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,514.00	14,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,414.00	457.00
EKG/ECG	770.00	0.00	MRI SERVICES	0.00	8,958.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,664.00	17,860.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	237.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,615.00	108.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,715.44	361.65
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	405.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	758.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	104.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	5,699.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,738.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,274.00	0.00			

TOTAL ANCILLARY	50,428.68	53,238.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	50,428.68	53,238.14

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	24,031.10	ADJUSTMENTS	387.78
COVERED CHARGES	22,807.18	CONTRACTUAL ALLOW	21,789.06
NON-COVERD CHARGES	1,223.92	TOTAL MEDICAID LIAB	1,018.12
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	991.12
		TOTAL NUMBER OF CLAIMS	17

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
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	46.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	766.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,276.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,497.00	105.00
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	177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,606.00	234.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,439.18	185.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	699.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	22,807.18	1,223.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,807.18	1,223.92

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	1,453.92	ADJUSTMENTS	0.00
COVERED CHARGES	1,373.00	CONTRACTUAL ALLOW	118.17
NON-COVERD CHARGES	80.92	TOTAL MEDICAID LIAB	1,254.83
		LESS: COB	1,251.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 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	36.00	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	1,337.00	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	80.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	1,373.00	80.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,373.00	80.92

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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CHARGES		PAYMENTS	
TOTAL CHARGES	64,370.31	ADJUSTMENTS	5,788.39
COVERED CHARGES	60,907.93	CONTRACTUAL ALLOW	49,313.15
NON-COVERD CHARGES	3,462.38	TOTAL MEDICAID LIAB	11,594.78
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	11,582.78

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

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	491.66	82.11	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,280.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,644.02	FEE SCHEDULE LAB	1,771.00	104.00
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	36,480.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,994.00	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	3,102.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,987.27	541.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,091.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P 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	5,509.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			

TOTAL ANCILLARY	60,907.93	3,462.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,907.93	3,462.38

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII
ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL
6325 HOSPITAL PARKWAY
JONES CREEK,GA 30097-5775

PROVIDER NUMBER
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/17 THROUGH 08/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

** END OF REPORT **